

Pam Chin-Lai MS, RD, LD, CEDRD.
Certified Eating Disorder Registered Dietitian

Date: _____

Client's name: _____

Client's address: _____

City State Zip Code

Home Phone: _____

Cell Phone: _____

Email: _____

Date of Birth: _____ Age: _____

If under 18 years of age

Parent's name: _____

Parent's address: _____

City State Zip Code

Home phone: _____

Cell phone: _____

Email: _____

Referred by: _____

I understand that appointment times are reserved exclusively for me therefore 24 hours advance notice is required for cancellations, otherwise full payment is due.

Signature: _____