95 Chambers Street • New York, NY 10007
Tel 347.557.8368 • Fax 646.304.1278
info@drreitzen.com

Name ______________________________ Date of Birth _______________________ Age __________ Gender_______
First + Last Month/Date/Year

Address ____ City __________________ State _________ Zip __________

Phone ____ Alternate Phone ____________________________________

Emergency Contact ____
Name Relationship Phone

Email Address ____ Occupation __________________________________

*Email is our preferred method of communication for appointment confirmations, test results, prescriptions/refills and billing matters. Please initial here _________ to indicate that you are willing to receive email correspondence related to your care from the practice.

How did you find Dr. Reitzen?

[ ] Physician Referral (please provide name) ____

[ ] Family/Friend Referral (please provide name) ____

[ ] Other (please describe) ____

Insurance information:

Primary Insurance Company ___________________________________ Plan ____________________________________

Out of Network Coverage? Y N

Policy Number _______________________________________Group ____

Insured Name _______________________________________ Social Security Number ____________________________

Date of Birth ____ Relationship ______________________________________

Secondary Insurance Carrier _________________________ ID _________________________ Group __________________

In compliance with new healthcare regulations, we send prescriptions electronically. Please provide us with your pharmacy information below. If you do not have a pharmacy of record, we can either recommend one for you or help you find one that is convenient.

Name ____________________________ Location __________________________________ Phone ___________________

I affirm that the above information is accurate and up to date:

Patient Name (print) ______________________________ Signature _____________________________ Date _________