CARIN H. GRIBETZ, M.D., P.C
969 PARK AVENUE, SUITE 1C
NEW YORK, NY 10028

NAME_____ AGE_____ DATE OF BIRTH_____

GENDER _____ MARITAL STATUS _____ EMAIL_____

ADDRESS_____
_____

HOME (_____)_____
MAY WE LEAVE A MESSAGE AT HOME AND/OR CELL REGARDING YOUR CARE AND APPOINTMENTS? _____
WORK (_____)_____
MAY WE LEAVE A MESSAGE AT WORK REGARDING YOUR APPOINTMENTS? _____
CELL (_____)_____

OCCUPATION _____ EMPLOYER _____
WORK ADDRESS_____

SPOUSE'S NAME _____ PHONE (_____)_____

WHO MAY WE THANK FOR REFERRING YOU? _____

PRIMARY CARE PHYSICIAN _____
PHONE NUMBER (_____)_____

MAY WE DISCUSS YOUR MEDICAL CONDITION WITH ANOTHER FAMILY MEMBER? _____
IF YES, WHOM _____ RELATIONSHIP _____

IN CASE OF EMERGENCY _____ CELL (_____)_____

IF PATIENT IS A MINOR PLEASE ENTER RESPONSIBLE PARTY INFORMATION
NAME_____ DATE OF BIRTH _____
ADDRESS _____
HOME (_____)_____ WORK (_____)_____ CELL (_____)_____

PLEASE NOTE: PATIENTS ARE RESPONSIBLE FOR FEES AT THE TIME OF VISIT.
WE WILL ASSIST YOU IN THE PROPPER PROCESSING OF YOUR INSURANCE FORMS.

I HEREBY AUTHORIZE CARIN H. GRIBETZ, M.D., P.C.:
TO RELEASE REQUESTED INFORMATION TO MY INSURANCE COMPANY
TO CONSIDER A PHOTOCOPY OF THIS REGISTRATION FORM AS VALID AS THE ORIGINAL
TO TAKE AND INCLUDE RELEVANT PHOTOGRAPHS IN MY PATIENT RECORD

PATIENT/GUARDIAN SIGNATURE _____**DATE** _____
THE INFORMATION ON THIS FORM IS PART OF YOUR PATIENT RECORD. IT THEREFORE RECEIVES THE SAME STRINGENT DOCTOR-PATIENT CONFIDENTIALITY SAFEGUARDS AS THE REST OF YOUR MEDICAL RECORD, INCLUDING STATUS PROVILEGED INFORMATION AND IS SUBJECT TO THE FEDERAL HIPAA CONFIDENTIALITY SAFEGURDS AND RULES.