Patricia R. Reiff M.D.,P.C

Patient Information

*Last*_____*First*_____*MI*_____

Sex__M__F Marital Status___Single__Married___Divorced__Widowed

*Date of Birth*_____*Social Security # (optional)*_____

Home # _____*Cell #*_____*Wk#*_____

*Mailing Address*_____

*City*_____*State*_____*Zip*_____

***Email Address*_____

*Emergency Contact*_____

*Phone#*_____*Relationship*_____

Advanced Health Directives

Do you have a living will? Yes____No____

Power of Attorney for Health Care? Yes____No____

*Any restrictions on life support? Yes____No____If yes, please indicate person to act on your behalf*_____*Relation*_____

Due to our new EMR system, we must ask the following:

*Race*_____*Ethnicity*_____

*Primary Pharmacy Name*_____

*Primary Pharmacy Address and/or Phone*_____

Medical Permission to Treat

This gives our office permission to medically examine and treat you and/or your minor child. You have the right to refuse any treatment that we recommend and we will document such refusal in your chart.

I have read, understood and consent to medical treatment.

*Patients name*_____

*Patient, Parent or Guardian signature*_____

Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Dr. Patricia R. Reiffs Notice of Privacy Practices.

*Patients name*_____

*Patients signature*_____*Date*_____