

UZZI REISS, M.D.
 414 N. Camden Drive Suite 750
 Beverly Hills, CA 90210
 Tel: 310-247-1300 • Fax: 310-205-0164

1. Your Personal and Identifying Information:

First Name		Birth Date	
Middle Name		Age	
Last Name		Marital Status	Single/Married/Divorced
Social Security No.		Driver's License No.	
Home Phone No.		Fax No.	
Pager No.		Mobile Phone No.	
E-mail Address (1 st)		E-mail Address (2 nd)	
Home Address	(Street)		
	(City)	(State)	(Zip)
Occupation		Office Phone No.	
Name of Employer			
Office Address	(Street)		
	(City)	(State)	(Zip)
Name of Spouse			
Social Security No.		Age	
Occupation		Office Phone No.	
Spouse's Employer			
Spouse's Office Address	(Street)		
	(City)	(State)	(Zip)
Your Internet Web or site Information:			
Please indicate the address and telephone number to which you would like all private communications sent:	(Address)		
	(Phone No.)		

2. Billing Information (*please note that Dr. Reiss does not bill insurance carriers for services rendered. Patients are personally responsible for payment of all services. However, he will give you a complete itemized statement for your own purposes):

Billing Name			
Relationship		Phone No.	
Billing Address	(Street)		
	(City)	(State)	(Zip)

3. Emergency Notification (*information should reflect the person most easily accessible):

Person to Contact			
Relationship		Phone No.	
Contact's Address	(Street)		
	(City)	(State)	(Zip)
Closest relative not living with you	Name		
	Relationship		Phone No.
	Address	(Street)	
		(City)	
	(State)	(Zip)	

4. Personal Physician:

Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)
I authorize you to obtain my medical records from this physician. (Please note that it would help Dr. Reiss in evaluation you to have this information.)	Signature		Date

5. Most recent physicians consulted, who would be able to provide relevant medical information about me:

Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)
I authorize you to obtain my medical records from this physician. (Please note that it would help Dr. Reiss in evaluation you to have this information.)	Signature		Date

6. I specifically request that you not contact the following physicians who have treated me in the past:

Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)
Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)
Name of the Doctor			
Speciality		Phone No.	
Office Address	(Street)		
	(City)	(State)	(Zip)

7. Please state the name and address of the individual that referred you to this office:

Name			
Speciality		Phone No.	
Address	(Street)		
	(City)	(State)	(Zip)