LESTER S. KRITZER, M.D.
ENDOCRINOLOGY AND METABOLISM
Watkins Centre
935 Main Street
Level B
Manchester, CT 06040

NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)
ADDRESS: _____
(STREET) (APT. #)
_____
(CITY) (STATE) (ZIP)
PHONE: _____ _____
(HOME) (WORK and/or CELL)

TO CONFIRM APPOINTMENTS: PHONE # _____ TEXT # _____

DATE OF BIRTH: _____ GENDER: _____

SOCIAL SECURITY #_____ ALLERGIES: _____

CIRCLE: SINGLE / MARRIED / WIDOWED / DIVORCED / DOMESTIC PARTNER

LANGUAGE PREFERENCE: _____

RACE: (**circle one**) American Indian/ Alaskan Native Black/African American Asian

White/Caucasian Hispanic/Latino ETHNICITY: (**circle one**) Not Hispanic/Latino Unknown Decline

IN CASE OF EMERGENCY:_____

FAMILY DOCTOR: _____
(NAME) (TOWN)
REFERRING PHYSICIAN: _____
(NAME) (TOWN)

WHO ARE YOUR DOCTORS WHO MIGHT WANT INFORMATION FROM THIS VISIT? (LIST NAME(S), AND TOWN(S)**:**

_____

LIST THE PHARMACY YOU USE, INCLUDE STREET AND TOWN: _____

INSURANCE: _____
(PRIMARY) (SECONDARY)

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH BENEFITS TO: LESTER KRITZER, M.D. TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNED TO RELEASE ALL INFORMATION TO SECURE THE PAYMENT. I UNDERSTAND THAT IF MY INSURANCE REQUIRES REFERRALS OR AUTHORIZATIONS THAT I AM RESPONSIBLE TO OBTAIN IT. IF REFERRAL IS NOT OBTAINED AT THE TIME OF VISIT I AM RESPONSIBLE FOR ALL CHARGES AT THE TIME OF VISIT.

_____
(SIGNATURE OF RESPONSIBLE PARTY) (RELATIONSHIP TO PATIENT) (DATE)

You acknowledge and agree that by signing this form, you are providing prior, express consent for Lester S. Kritzer, M.D. his providers, agents and contractors, including debt collection agencies, to place calls to your designated cellular or residential phone using any type of artificial or pre-recorded voice or auto-dialer technologies for any purpose permitted by law. You are not required to agree to this section in order to receive services from Lester S. Kritzer, M.D.

_____
(SIGNATURE OF RESPONSIBLE PARTY) (RELATIONSHIP TO PATIENT) (DATE)