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Diplomate in Neurology American Board of Psychiatry and Neurology

## Patient Intake Form

PLEASE ANSWER ALL QUESTIONS AND PRINT CLEARLY, THANK YOU      DATE \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel \_\_\_\_\_ Cell \_\_\_\_\_ Work Tel \_\_\_\_\_

**INSURANCE NAME:** \_\_\_\_\_ Member ID# \_\_\_\_\_

Policy holder \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to policy holder: \_\_\_\_\_ Insurance phone number: \_\_\_\_\_

Insurance address \_\_\_\_\_

Which device do you have? Computer/laptop, iPad, iPhone \_\_\_\_\_

Do you have a high-speed WiFi connection? \_\_\_\_\_ Room with chair/desk/table \_\_\_\_\_

Do you have a pen light? \_\_\_\_\_ Do you have a home blood pressure cuff? Scale? \_\_\_\_\_

### List your medications:

Name	Milligram/pill	# of pills	# of times/day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other changes since your last visit: \_\_\_\_\_

\_\_\_\_\_