WELCOME TO OUR PRACTICE

PLEASE FILL OUT THE INFORMATION BELOW FOR OUR RECORDS.

Today's Date______________________

Patient's name____Date of birth______________Age_______

Address_____________________________City_____________________State_________Zip__________

Home Phone_____________________ Cell phone_____________________ Pager__________________

Employer______________________________________ Work phone______________________________

Employer Address_______________________________ City_________________ ST_____ Zip________

Emergency contact_______________________________________Phone___________________________

Social Security # _________________________

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT

Responsible party____Relationship to patient_____________

Address__________________________ City____________________ ST_______ Zip_______________

SS#__________________________Birthdate_____________ Work phone________________________

Employer Name___________________________ Address_____________________________________

City__________________________ State___________ Zip_____________________

INSURANCE INFORMATION

Insurance company____

Name of insured____Relationship to patient_____________

Employer name____________________________ID#_____________________Group#_______________

AUTHORIZATION AND RELEASE OF INFORMATION

I authorize Louis L. Strock, M.D., P.A. to release information to other health professionals and/or my insurance carrier concerning any illness or treatment and assign Louis L. Strock, M.D., P.A. all payments for services rendered to me or my dependents. I understand that I am responsible for any charges incurred regardless of insurance coverage.

Signature____Date_________________________

Name________________________________ Date of birth___________________ Age______________

Type of consultation you are requesting____

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

__Arthritis
__ASTHMA
__Back trouble
__Bleeding tendencies
__Cancer

__Diabetes
__Epilepsy or seizures
__HEART DISEASE
__Hard of Hearing
__High blood pressure

__Kidney disease
__Lung/Respiratory problems
__MITRAL VALVE PROLAPSE
__Rheumatic fever
__other___________________

Previous surgeries____

____

____

Current medication____

____

Drug allergies or sensitivities____

____

History of smoking: No_____ Quit (year)______ Yes_____ packs per day?___________________

Height________________ Weight_________________

Primary Care Physician____ Phone________________

Referral required No______ Yes_______

Pharmacy name & phone number____

Who may we thank for your referral?____