WELCOME TO OUR PRACTICE

FILL OUT THE INFORMATION BELOW FOR OUR RECORDS.

Today's Date______________________

Patient's Name_______________________________________Date of Birth______________Age_______

Address_____________________________City_____________________State_________Zip__________

Cell Phone____________________________________ Email___________________________________

Employer______________________________________

Emergency contact_______________________________________Phone___________________________

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT

Responsible Party____Relationship to patient_____________

Address__________________________ City____________________ ST_______ Zip_______________

Birthdate_____________ Phone________________________

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______________________

STROCK PLASTIC SURGERY
LOUIS L. STROCK, M.D. P.A.

Name_______________________________ Date of birth___________________ Age______________

Type of consultation you are requesting____

MEDICAL HISTORY
PLEASE CHECK ALL THAT APPLY

__Asthma
__Back trouble
__Blood Clots
__Bleeding tendencies
__Cancer
__Diabetes
__Epilepsy or seizures
__Heart Disease
__History of UTI's
__High blood pressure
__Kidney Disease
__Lung/Respiratory problems
__Massive weight loss
__Mitral Valve Prolapse
__Thyroid Disorder
__Other___________________

Previous surgeries____

____

Current medications(including weight loss meds)____

____

Current supplements or energy drinks____

____

Drug allergies or sensitivities____

____

History of smoking/Vaping (including THC):
No_____ Quit (year)______ Yes_____ Amount per day?___________________

Height________________ Weight_________________

Primary Care Physician____ Phone________________

Pharmacy name & phone number____

Pharmacy Address ____

Who may we thank for your referral?____