David Stoker, M.D.
Patient Information Form

Patient _____
first middle initial last

⑨ Single ⑨ Married ⑨ Divorced ⑨ Widowed

⑨ male
Date of Birth _____ Age _____ ⑨ female

SS # _____-_____-_____

Address _____

City _____ ST _____ Zip _____

Phone # _____ _____
home work

Cell # _____

E-mail Address _____

I consent to communicating via: Text Messaging YES NO
Non-encrypted email YES NO

I understand that email and text messaging are not secure and may contain protected health information. _____
(Patient Initials)

May we email you news and special offers? YES NO

Employer _____

Employer's Address_____

City_____ ST _____ Zip_____

Occupation _____

Insurance Information

Insurance _____PPO/HMO/EPO

Member ID # _____

Group # _____

Primary Care Physician (complete in full)

Physician's Name _____

Address_____

Phone #_____

How did you first hear about Dr. Stoker?

I am a previous patient of Dr. Stoker: _____Yes _____No

I was referred by a patient of Dr. Stoker:

_____
Name and relationship to referral

May we send a thank you note to them? Yes No

I was referred by a physician: _____
Name of Physician

I was referred by an internet site (circle all that apply):

DrStoker.com Google RealSelf Yelp TV

Other_____

Person to contact in case of emergency

Name _____Relationship _____

Address _____

Phone # _____ _____
home cell

Authorization for Payment/Release of Medical Records

"I authorize release of medical records and payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance."

Signature _____ Date _____

Photography Consent

"I authorize the physician or assistant to take photographs or video recordings of me. These are the doctor's property and will be a permanent part of the medical record. The photographs or videos may be used for teaching, lectures or educational publication."

Signature _____ Date _____