David Stoker, M.D.
Patient Information Form

Patient _____
first m.i. last

❒ Single ❒ Married ❒ Divorced ❒ Widowed

Date of Birth _____ Age _____ ❒ male ❒ female

SS # _____-_____-_____

Drivers License # _____

Address _____

City _____ ST _____ Zip _____

Phone # _____ _____
home cell

_____ _____
work extension

E-mail Address _____

Can we contact you by email? Yes No _____
(patient initials)

Employer _____

Employer's Address_____

City_____ ST _____ Zip_____

Occupation _____

Person Responsible for Bill (complete in full or ❒ same as above)

❒ Self ❒ Spouse ❒ Parent ❒ Guardian ❒ Employer ❒ other_____

Name _____

Address _____

City_____ ST _____ Zip_____

Phone # _____ _____
home work

Employer _____

Employer's Address_____

City_____ ST _____ Zip_____

Occupation _____

Photography Consent

I authorize the physician or assistant to take photographs. The term "photograph" includes Polaroids, 35mm slides, standard photographs, videotape, etc. These photographs are the doctor's property and will be a permanent part of the record. These may be used for teaching, lectures, educational conferences or publication.

Signature _____ Date _____

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 _____

Insurance Information

My plan is a: ❒ PPO ❒ HMO ❒ POS (point of service) ❒ EPO ❒ other

Patient's relationship to responsible party:
❒ Self ❒ Spouse ❒ Child ❒ Guardianship ❒ Employee ❒ other_____

Primary Insurance _____
Secondary Insurance (if applicable)_____
Member ID # _____Group # _____

Primary Care Physician (complete in full)

Physician's Name _____
first last

Address _____

City _____ ST _____Zip_____

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 StokerPlasticSurgery.com Google RealSelf Yelp

Other_____

I saw Dr. Stoker on TV: _____
Name of TV show

Person to contact in case of emergency

Name _____Relationship _____

Address _____

City_____ ST _____ Zip_____

Phone # _____ _____
home cell

Authorization for Release of Medical Records

To: _____

I hereby authorize you to release any information including diagnoses and records of any treatment or examination rendered to me.

Signature_____

Printed name of patient _____

Date _____ Witness _____