STRAITH CLINIC

Please make every effort to fill out the following information clearly. This information is held confidentially.

****** P L E A S E   P R I N T ******

Mr. Ms. Mrs. Dr.

Name ____

Single ☐ Married ☐ Divorced ☐ Widow ☐

Date of birth ____________________ Age_______ Sex ____

Home address ____________________________________

City _______________________ State _____ Zip________

Contact information:

Home (______) _________________________________

Work (______) _________________________________

Cell (______) _________________________________

Email ____

____

Doctor you wish to see _____________________________

No preference _____

Insurance Information

Name of health insurance company:___________________

____

Name on insurance card: ___________________________

Group #: ____

Policy/ID #: ______________________________________

Employer of card holder:____________________________

Where employed __________________________________

Occupation _______________________________________

Have you ever been to the Straith Clinic before?

Yes ☐ No ☐

If yes,

Approximate year: ______________________________

Previous name?:________________________________

Procedures(s) you are contemplating: ____

____

Please help us find out what source(s) you used for your research on cosmetic surgery and/or plastic surgeons.

(check all that apply)

☐ Straith Clinic Website

☐ Other Internet Source: (please name website if possible) ______________________________________

Facebook, FaceForum, Google, Healthgrades, ImplantInfo, Liposite, LocateAdoc, LookingYourBest, PlasticSurgeryORG, RealSelf, RateMDs, Website EMAIL, Vitals, Yelp

☐ Reputation

☐ Recommendation or Referral (Please name person, ie., former patient, doctor) ______________________________

Comments____

____

NOTE: Patient records are maintained for the required period of ten years. If you desire copies of your records, they must be requested in writing prior to that time frame. Taping of all consultations is strictly forbidden without prior written consent of the patient, doctor, and/or employee. Please acknowledge by signing.

____

patient (if minor, parent/legal guardian) Date