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_____ Gender_____

Home address _____

City _____ State _____ Zip_____

Contact information:

Cell # (_____) _____

Home # (_____) _____

Parent # (if minor) (_____) _____

Patient Email _____

Parent Email (if minor) _____

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) _____
Ie: Facebook, Instagram, Google, Yelp, Healthgrades, RealSelf, RateMDs, Website EMAIL, Vitals

☐ 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