PATIENT INFORMATION FORM

Dr. Richard J. Strauch
2-B Waln Street
Wellsboro, PA 16901
(570) 724-4042
www.drstrauch.com

Are you a referral? ___Yes ___ No What is the reason for your visit _____

Who referred you or how did you learn about us? _____

Patient Name: _____ Gender____ Date of Birth _____ Age ____

Address _____

Home _____ Cell _____ Marital Status ___M ___S ___ D ___W

Email address: _____

Employer _____

Who did you bring with you today? _____, relationship _____

Emergency Contact:

Name_____ Relationship_____

Address_____ Phone _____

Medical Information: Type of Insurance: _____

****Please provide receptionist with your insurance card (s) so that a copy may be made****

Allergies_____

_____

High Blood Pressure _____ Diabetes _____ Other _____

Current medications_____

_____

Consent to release information:

I, the undersigned, request and authorize Dr. Richard Strauch, to furnish or release whatever medical records or other information which he deems appropriate relative to the above named patient's medical treatment to:

_____ _____

(name of your primary doctor) (signature of patient or authorized person)