David P. Stapenhorst, M.D., F.A.C.S.

Patient Information

Date:_____

Name:_____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

e-mail:_____

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ e-mail

Do you authorize us to leave a message on your phone? ☐ No ☐ Yes
Do you have any contact restrictions? ☐ No ☐ Yes (please explain) _____

Social Security Number:_____ Driver's License Number:_____

Reason for today's visit:_____

Referred by: ☐Website ☐Internet Ad ☐Print Ad ☐ Other_____
☐Phycian (name)_____ ☐Friend (name)_____

Primary Care Physician _____

Patient's Employer

Employer:_____ Occupation:_____
Address:_____ City:_____ State:_____ Zip Code:_____

Emergency Contact

Name:_____Relationship:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

Insurance Information

Insured Party (If not self)

Name:_____ Date of Birth:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Social Security Number_____

Primary Insurance

Company:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____

Policy/ID Number:_____ Group Number:_____

Secondary Insurance

Company:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____

Policy/ID Number:_____ Group Number:_____

Assignment of Benefits

_____ _____

Signature Date