



Shoulders & Knees

Steven Struhl MD

REGISTRATION

Name _____ Age _____ Date of Birth _____

Address _____ Married Single

_____ Social Security # _____

Cell phone # _____ Occupation _____

Home phone # _____ Employer Name _____

Business phone # _____ Medical Doctor _____

Email _____ Medical Doctor phone # _____

Emergency Contact Name _____ Emergency Phone # _____

Referral Information (how did you get referred to our office?)

What is your main symptom?

Did you have an injury? Yes No If yes, what was the **date**? _____

If yes, was it **Automobile** related or **Work** related?

If there was no specific injury how long have you had symptoms? _____

Do you have any allergies to prescription drugs? Yes No If yes, which? _____

What prescription medication are you currently taking? Please list:

Do you have any medical problems such as high blood pressure, diabetes, heart disease, asthma, seizures, hepatitis, anemia or any other? Please circle and/or explain below:

Have you ever had a stress test and if so when?

What is your height and weight? BP: _____

Do you smoke? Yes No If yes, how much?

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with _____ and assign directly to **Dr. Struhl** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date