Dr. David Strobel, M.D.

716 Maiden Choice Lane, Suite 305 Catonsville, MD, 21228-5961 Phone (410) 747-9422 Fax (410) 747-4871

Patient First _____ M.I. ____ Last _____ Suffix _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ / _____ /_____ Social Security # _____ / _____ / _____

Gender M / F Marital Status S / M / D / W Race Asian / Black / Caucasian / Hispanic / Native American / Other

Phone# Home (___) _____ -_____ Work (_____) _____ - _____ ext. _____

Mobile(____) _____- _____ Email _____

Pharmacy Name _____ Address_____ City_____ Zip code _____

Referring Dr. Name_____ Phone# (____) _____ - _____

If you are over the age of 65, have you had the pneumonia vaccine? Yes / No

If you are a female between the ages of 40-69, have you had a mammogram? Yes / No

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Primary Insurance
Insurance Company _____

Policy Holder's Name _____

Policy Holder's Address_____

Relationship to Patient _____

Policy Holder's Date of Birth _____ / _____ / _____

Secondary Insurance
Insurance Company _____

Policy Holder's Name _____

Policy Holder's Address _____

Relationship to Patient _____

Policy Holder's Date of Birth _____ / _____ / _____

Emergency Contact Name _____ Address _____

Phone # (_____) _____- _____ Relationship to Patient _____

Guarantor Name _____ Social Security # _____ - _____ - _____ Phone # _____

Address _____ Relationship to Patient _____

Please list your current

Medications_____

_____

Allergies _____

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatments. I hereby assign, transfer, and set over to David Strobel, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me, revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

I certify that I have read this form and understand its contents.

Signature **Date** _____