

RUSSELL B. STOKES, MD

A Medical Corporation

216 W. Pueblo Street, Suite A, Santa Barbara, CA 93105
Tel: 805-687-0080 Fax: 805-687-4247

Welcome!

Please provide us with a little information about yourself...

Name: _____ Date: _____

Male__Female__ Birthdate___/___/___ Social Security Number____-____-____

Marital Status S__M__D__W__ Drivers License # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () - Alternate Phone: () - Email: _____

If necessary, can we leave a message saying we are calling from Dr. Stokes' office? Yes ___ No ___

Employer: _____ Occupation: _____

EMERGENCY CONTACT _____ Phone _____

How were you referred to our office? _____

WHAT PROCEDURE(S) WOULD YOU LIKE TO DISCUSS? _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SS# _____

Relationship to Insured _____ Insured's Employer _____

Insurance Company _____ Policy # _____

I authorize the release of any medical information necessary to process my medical claim, and I authorize payment of medical and surgical benefits to Dr. Russell B. Stokes when applicable. I accept financial responsibility for treatment rendered.

Signature: _____ Date: _____