**Stuart A. Linder, M.D., Inc.**
**Plastic and Reconstructive Surgeon**
**Certified by the American Board of Plastic Surgery**
**A California Professional Medical Corporation**
**9675 Brighton Way, Suite 420**
**Telephone (310) 275-4513**
**Fax (310) 275 4813**

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## General Patient Information

Welcome to our office. In order to serve you most efficiently, please fill out the following information which will be held strictly confidential.

**PERSONAL INFORMATION**

Last Name: _____First:_____M.I._____
**Home Phone**:_____**Cell**:_____ **Work**:_____
Home Address:_____
City:_____State:_____Zip:_____
**Date of Birth**:_____Marital Status: Married Single Other
**Social Security** #: _____Email:_____
Employer:_____Occupation:_____
Person to be notified in case of emergency:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Work/Day Phone:_____
**How Did You Hear of Us**?_____
Referring Physician (If Applicable):_____
Primary Care Physician:_____
PCP's Phone Number:_____

**INSURANCE INFORMATION**

Insurance Company Name:_____
Subscriber Name:_____
Relationship to Subscriber: Self Spouse Parent Other
ID# that appears on your card:_____
Group# (If applicable)_____

I authorize payment of medical benefits to Stuart A. Linder, M.D., Inc.
I authorize this office to release to the named insurance company any information Necessary to expedite insurance payment. I understand that I am responsible for all Charges, regardless of insurance coverage.

Signed:_____Date:_____

**CONFIDENTIAL MEDICAL QUESTIONNAIRE**

**Patient Name:**_____**Date:**_____
Present Medications (Including vitamins, supplements, and herbs):
Name of Meds Dosage Frequency Duration Taken For
1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

Do you smoke? Yes No Year you stopped smoking? _____
Special Diet? _____
Alcohol Intake?_____Frequency?_____
Type of Exercise?_____Frequency?_____

Please list chronologically any and all hospitalizations and/or operations you have had
Date Purpose of Hospital Visit Type of Operation (Including elective surgery)
1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

Do you have or have you ever had any allergic reaction to any prescription or non-prescription medications or drugs? Yes No
If Yes, please detail below:
Name of Medication:_____
Any other Reactions:_____
Any other Allergies:_____
Do you have a Latex Allergy?_____

Do you have or have you ever had….Please circle all that apply:
Arthritis Yes No Ulcer Yes No Liver Problems Yes No
Anemia Yes No Stroke Yes No Heart Problems Yes No
Asthma Yes No Cancer Yes No Skin Problems Yes No
Seizures Yes No Kidney/Urinary Problems Yes No
Diabetes Yes No Serious Injury Yes No
Have you been treated for Depression? Yes No When? _____
Any serious illnesses/conditions not mentioned? Please Detail: _____
_____

Have you known or suspected exposure to TB, Hepatitis B, C, or HIV? Yes No
If yes, please give us as much detailed information as possible, including years of exposure:
_____ Please inform us if any information changes. Thank you and we appreciate your time!