J. ANTHONY STEPHENS MD

(225) 767-7575

Patient Information as of

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ☐ No ☐ Yes Restrictions: ____________

Email:____________ ____________

Age ______ Birthdate ___/___/___ SS# ___-___-_____ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: ____________ ☐ Other: ____________

Occupation:____________ Place of Employment:____________

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Address ____
Street & Apt # City State Zip

Reason for Office Visit ____

How did you hear about our office? ____

Signature ______________________________ **Date** ____________

J. Anthony Stephens MD
5233 Dijon Dr.
Baton Rouge, LA 70808-4312
Phone: (225) 767-7575 Fax: (225) 768-7470
janine@doctorstephens.com

Date of Service:

Patient:

Your Goal from a surgical procedure:

Requested date or month of procedure:

Any other information that you think may be helpful to achieving your goals:

MEDICAL INFORMATION

Medical History: Chronic Illness

High Blood Pressure Anemia Diabetes Thyroid Trouble Asthma

Heart Disease Other: ______________________________

Medical History: Serious Illness

Heart Attack Pneumonia Trauma Other:______________________

Medications:

Past Surgical Procedures:

Do you smoke, if so how much and for how long:

Do you take or have you ever taken any type of Diet Pills:

Allergies: **Reaction:**

Do you have a latex allergy?

Do you drink alcoholic beverages? If so, how often and how much?

# of pregnancies **# of children** **Current weight:** **Current height:**

Signature_____________________________________ **Date**_______________