The Retreat European Aesthetics
Dr. Roxana Stoici
2837 1st Avenue North St. Petersburg, FL 33713

Patient Information

Who is your appointment with today (Please Circle):

□ Dr. Roxana Stoici

Date____________________

Social Security______________________________

Last Name__________________________________ First Name__________________________MI_____

Address____

City____________________________________State__________Zip___________________________________

DOB: Month_______Day_______Year_________ Age_________ □ M □ F Marital Status________

Home Phone______________________Cell_____________________Work______________________________

Email Address____

Referred By________________________________ Family Physician____________________________

Reason for your appointment today____

Main Complaint____

Employer____________________________________Address____

In Case of Emergency Notify_______________________________Phone Number________________________

INUSRANCE INFORMATION Claim #______________________Authorization#______________________

Insured Name______________________________ Insured DOB________________________________

Relationship to Patient: □ Self □ Parent □ Child Insured ID#_________________________________

Insurance Company Name_______________________________Phone Number___________________________

Insurance Company Address___________________________________City/State/Zip______________________

Contact Name or Adjuster______________________________If Accident, Date of Accident______________

Precert/Preauthorization#__________________________ Required □Yes □No Phone #___________________

Insured ID#_______________________Patient ID#_________________________Group#___________________

Insured Employer____________________________Insurance Fax #______________________________________

Secondary Insurance Name____________________________Phone____________________________________

Claims Address______________________________________City/State/Zip_______________________________

Insured ID #__________________________Patient ID Number________________Group#_________________

Patient/Parent/Guardian____________________________________Date______________________________