World Renowned Stem Cell Expert

Sports and Regenerative Medicine Centers

A STEM CELL CENTER OF EXCELLENCE

DENNIS M. LOX M.D.

**Clearwater, Florida**
**Beverly Hills, California**

**info@drlox.com**

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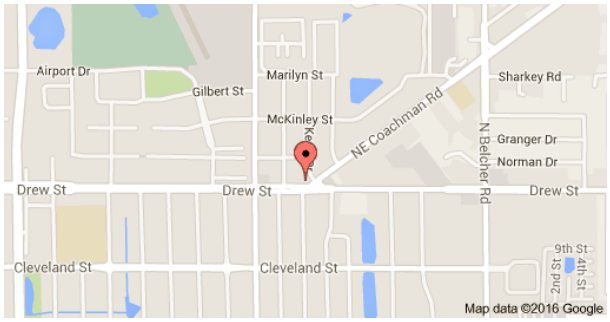
Dear New Patient,

Thank you for choosing Dennis M. Lox, M.D to participate in your healthcare. We realize that you could have chosen any other office, so we are honored that you have chosen us. While Dr. Lox has cared for thousands of patients since starting his practice in 1990, we treat each of our patients as individuals and attend to their unique needs.

Attached is an initial intake questionnaire, designed to make your initial visit much more efficient. Please do your best to complete each section of the questionnaire so that we can have as much information about you as possible.




Our office is located at 2030 Drew Street, Clearwater FL, 33765.

We are on Drew Street, in between N.E Old Coachman Road

and Hercules Avenue.

If you have any questions before your appointment, please feel free to contact our office via telephone; 727-462-5582, via email; info@drlox.com, fax; 727-462-5583.

Again, thank you for choosing Dr. Lox and we look forward to meeting you!

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Today's Date: _____ Social Security Number: _____

Name: _____

Date of Birth: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Relationship To You: _____

In the event of an emergency, may we release your medical information to this person? YES NO

May we leave a voicemail on your answering machine to confirm your appointment? YES NO

Primary Care Physician: _____ Phone: _____ Fax: _____

**INSURANCE INFORMATION**

**PRIMARY:**

Insurance Carrier: _____ HMO or PPO Referrals Required? YES NO

Member Identification Number: _____ Group Number: _____

Claims Address (PO BOX on back of card): _____

Policy Holder: _____ Relationship: _____ D.O.B: _____

Deductible: _____ Copay: _____

**SECONDARY:** ☐ **N/A**

Insurance Carrier: _____ HMO or PPO Referrals Required? YES NO

Member Identification Number: _____ Group Number: _____

Claims Address (PO BOX on back of card): _____

Policy Holder: _____ Relationship: _____ D.O.B: _____

Deductible: _____ Copay: _____

**Patient Name:** _____ **Date of Birth:** _____

**Age:** _____ **Height:** _____ **Weight:** _____

**Chief Complaint:**

_____

_____

**Are you currently taking any anticoagulants?** YES or NO

**Current Prescribed Medications:**

_____
_____
_____
_____
_____
_____

**Allergies:**

_____
_____
_____
_____
_____

**Are you allergic to any of the following?**

Aspirin Lidocaine Betadine / Iodine Tape Latex

**Social History:**

**Occupation:** _____ **Marital Status:** S M D

**Children:** Yes No If Yes, How Many: _____ **Tobacco Use:** YES NO

**Nutrition:** Currently On A Diet? Yes No Explain: _____

**Past Medical History:**

Have you ever had or currently have cancer? NO YES radiation chemotherapy (please circle)

If Yes, Please Specify: Breast Prostate Other: _____

**Radiology: (Most Recent)**

XRAY/MRI _____DATE: _____ XRAY/MRI _____DATE: _____

**Surgical History**

**YEAR**

**Knee** L _____ explain: _____

R _____ explain: _____

**Shoulder** L _____ explain: _____

R _____ explain: _____

**Hip** L _____ explain: _____

R _____ explain: _____

**Lumbar** explain: _____

**Cervical** explain: _____

**Other:** _____

**Chronic Medical Problems (Please Circle)**

Hypertension Diabetes Gout Asthma Arthritis Renal Disease Thyroid Disease

Coronary Heart Disease COPD

**Family History (Please Circle)**

Cancer Hypertension Hyperlipidemia Diabetes Coronary Artery Disease Arthritis OA RA

RF Disorders Lupus

**How did you hear about Dr. Lox? (Please Circle)**

RADIO INTERNET DOCTOR PATIENT TELEVISION OTHER _____

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# Authorization for Medical Treatment
# And
# Assignment of Benefits

Patient Name: _____

Date: _____

I, the undersigned patient, authorize Dennis M. Lox, M.D to carry out such examinations and diagnostic procedures, and to administer such treatments as may be deemed medically necessary or advisable.

I hereby certify that I have read and fully understand the above authorization for medical treatment and diagnostic procedures. (if necessary)

Further, I assign directly to Dennis M. Lox, M.D all medical insurance benefits otherwise payable to me for ALL services rendered. I understand that I am fully responsible for ALL charges, whether or not covered by my insurance. I hereby authorize Dennis M. Lox, M.D to release any of my personal information necessary to secure payment of benefits.
I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS ON MY BEHALF.

_____ _____

Patient Signature

Signature of Legal Guardian/Resp Party
(if under 18)

_____ _____

Patient Printed Name

Printed Name of Legal Guardian/Resp Party

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# Authorization to Release Medical Records

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____ Last 4 Digits of Patient SSN: _____

Doctor / Medical Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

I authorize the healthcare provider/facility named above to release a copy of my medical records to include all office notes, films and diagnostic test results and forward them to:

**Dennis M. Lox, M.D**
**2030 Drew Street**
**Clearwater, FL 33765**
**Phone: 727-462-5582**
**Fax: 727-462-5583**

**This authorization is valid for one year from the date above.**

_____
Patient Signature

**OR**

_____
Witness

_____
Signature of Legal Guardian or
Responsible Party (under 18)