Stuart B. Krost, M.D., P.A.

STUART B. KROST, M.D., FAAPM&R, FAAPM, CIME

Physical Medicine & Rehabilitation, Pain Management

☐ **Administration Office**
3618 Lantana Rd, Ste 201 Lake Worth, Fl 33462
Phone: 561-296-2220
Fax: 561-420-8178
www.wetreatpain.com
NP@WeTreatPain.com

☐ **Port St. Lucie:** 1903 SE Port St. Lucie Blvd, Port St Lucie FL 34952
☐ **Plantation:** 7300 NW 5th St, Plantation FL 33317
☐ **Miami:** 9220 SW 72nd St Ste 106, Miami FL, 33173
☐ **Ft. Myers:** 3615 Central Ave Ste 3, Ft. Myers FL 33069

Patient: _____ **Date of Birth:** _____ **Sex: M / F**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Social Sec:** _____ **E-Mail:** _____

Attorney: _____ **Phone:** _____ **Fax:** _____

Date of Accident: _____ **E-Mail Address:** _____

Primary Ins./Auto: _____ **Member/ID:** _____ **Group/Claim:** _____

Ins. Adjuster/Rep.: _____**Ins. Phone:** _____ **Ins. Fax:** _____

☐ **EVALUATION & TREATMENT**

FACETS	EPIDURALS	JOINT INJECTIONS
☐ CERVICAL	☐ CERVICAL	☐ ELBOW
☐ LUMBAR	☐ LUMBAR	☐ KNEE
☐ THORACIC		☐ SHOULDER
		☐ SI JOINT

TRIGGERPOINT INJECTIONS	HEADACHE	EMG
☐ CERVICAL	☐ BOTOX	☐ LOWER
☐ LUMBAR		☐ UPPER
☐ THORACIC		

☐**Additional/other requested services:** _____

_____

NOTE: Please e-mail or fax this form to our office once an appointment has been so that we may document the day, time & location in our system. Our new patient depts. e-mail is: NP@wetreatpain.com, and the fax # is 561-420-8178.

Appointment Details:

App. Date:_____ **App. Time:**_____ **Clinic Location:** _____

Referring: **Referring Signature:** **Date:**

_____ _____ _____