Friedman Surgical Group, P.C.

WELCOME TO OUR OFFICE

Today's date: _____ Birth date: _____

Last name: _____ First name: _____

Address: _____ City: _____ ZIP: _____

Home #: _____ Mobile #: _____

Work #: _____

Sex (M/F/T): ___ SS #:_____ Marital (S/M/W): ___

Employer/Occupation: _____

Spouse name: _____

Primary Doctor: _____ Referring: _____

Cardiologist: _____ Oncologist: _____

HEALTH INSURANCE (*if patient is not subscriber*)

1st Insurance: SUBSCRIBER'S NAME: _____ Birthdate: _____

2nd Insurance: SUBSCRIBER'S NAME: _____ Birthdate: _____

Please list your allergies:

_____

Please list your medications:

_____

_____

_____

Are you taking blood thinners, please list:

_____

Are you diabetic? (Y/N): ___ Insulin (Y/N): ___ Oral Medication (Y/N): ___

Do you smoke? (Y/N): ___ How much? _____

If you quit, when (MM/YY): _____

E-cigarettes (Y/N): ___ Marijuana (Y/N): ___

Cigars (Y/N): ___ Chew tobacco (Y/N): ___

Revised: 04/30/2020