BAYWOOD SURGICAL ASSOCIATES, PC

REGISTRATION FORM

Please print this form, complete at your convenience and bring with you to your first appointment. Thank you!

Date_____

Mr. _____ Mrs. _____ Miss_____ Ms. _____

Name: _____ Age:____

Street Address:_____

Mailing Address:_____

City:_____ State:_____ County:_____ Zip:_____

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

Employer:_____

Sex: M / F Marital Status: Single / Divorced / Married / Widowed

Social Security Number:_____-_____-_____Date of Birth ____/____/_____

HOW DID YOU HEAR ABOUT US?_____

Family Physician: _____

Patient's Spouse / Parent, if Child:_____Work Phone:_____

Nearest relative or friend (NOT LIVING WITH YOU)(for emergencies)

Name: _____ Relationship: _____

Phone Home:_____ Work:_____

Insurance: Please list the subscriber of the policy if other than the patient.

PRIMARY: _____

Policy#_____ Group# _____

SECONDARY: _____

Policy#_____ Group# _____

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MEDICAL HISTORY

Date_____

Reason for your Visit:_____

Have you ever had:

Diabetes: ☐ High Blood Pressure: ☐

Heart Disease: ☐ Thyroid Disease: ☐

Kidney Disease: ☐

Do you smoke? Y / N If yes, how many packs per day? _____

SURGICAL HISTORY:

Type of surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Any anesthesia complications or reactions?_____

MEDICATIONS (including birth control and supplements)

Name	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Name of Drug	Reaction
_____	_____
_____	_____
_____	_____

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