RECALL PROCEDURE FORM

NAME: ________________________________DOB: __________________

AGE: ______ PROVIDER: ______________PROCEDURE: ____________

PLEASE COMPLETE THIS FORM AND MAIL BACK TO US. WE WILL CALL YOU TO SCHEDULE AFTER REVIEWED

1. Do you have any heart problems? Ex. congestive heart failure, atrial fibrillation Have you ever had a heart attack? Have you ever had heart surgery? Ex. Open heart, stent(s), artificial valve pacemaker or internal defibrillator When? ______________ If yes, please explain ______________________________ Who is your cardiologist? ______________________________	YES YES YES	NO NO NO
2. Do you take medication for high blood pressure or heart disease? If so, who is the prescribing doctor? ______________________________	YES	NO
3. Do you have any kidney problems? ______________________________ Are you currently on dialysis?	YES YES	NO NO
4. Have you ever had a stroke? If so, when? _________Any impairment from it? ____________________	YES	NO
5. Do you take any blood thinners? Ex. Plavix (clopidogrel), Pletal (cilostazol), Effient (prasugril), Brilinta (ticagrelor), Coumadin (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Lovenox, Savaysa (edoxaban), Aspirin? If yes, why? ______________________________ Who is your prescribing doctor? ______________________________	YES	NO
6. Do you have any respiratory problems?Ex. tuberculosis, emphysema, COPD, asthma If yes, please explain ______________________________	YES	NO
7. Have you ever been diagnosed with sleep apnea? If yes, do you use a C-Pap/Bi-Pap machine? ____________________	YES	NO
8. Have you ever had any serious problems with Anesthesia? Ex. Hard to intubate, stopped breathing, dangerously high/low blood pressure, injuries to your nose, neck or back If yes, please explain ______________________________	YES	NO
9. Do you have any other health problems or changes in your health status? If yes, please explain ______________________________	YES	NO
10. Have you been hospitalized in the past 30 days? If so, why? ______________________________	YES	NO
11. Do you (the patient) live in a nursing home / assisted living facility?	YES	NO
12. What is your approximate weight? __________________lbs. and height?____________________		
13. Who is your family physician? ______________________________		

PLEASE LIST THE PHONE NUMBER TO REACH YOU DURING BUSINESS HOURS

Home: (_____)______-_________ Cell:(_____) _______-_________ Work:(_____) ______-__________

PLEASE COMPLETE MEDICATION LIST AND INSURANCE INFORMATION ON BACK ➡

OFFICE USE ONLY ** OFFICE USE ONLY ** OFFICE USE ONLY

ADDITIONAL INFORMATION:
BMI: ________

NAME:	**DOB:**
DATE:	

PLEASE LIST ALL CURRENT MEDICATIONS, OVER THE COUNTER DRUGS, HERBAL SUPPLEMENTS AND VITAMINS BELOW

IF YOU ARE NOT TAKING ANY OF THE ABOVE, PLEASE CIRCLE: NONE

EXAMPLE: NEXIUM	***40mg 1 tab once daily***
MEDICATION	**DOSAGE**

PLEASE LIST ALL ALLERGIES BELOW:

IF YOU DO NOT HAVE ANY KNOWN ALLERGIES, PLEASE CIRCLE: NONE

EXAMPLE: PENICILLIN	***HIVES***
ALLERGY TO	**REACTION**

PLEASE PROVIDE THE FOLLOWING INSURANCE INFORMATION:

***1st Insurance** ____________________Holder _______________DOB:________SSN:____________
Policy/ID# ____________________________ Group # _____________ Employer _______________
Claims Address ____
Benefit/Eligibility/Provider Service Phone #: ____

***2nd Insurance** ___________________Holder _______________DOB:________SSN:____________
Policy/ID# ____________________________ Group # _____________ Employer _______________
Claims Address ____
Benefit/Eligibility/Provider Service Phone #: ____

Patient Employer (if different than Ins. Holder): ____

* **PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS – FRONT AND BACK**