

Date of Birth: _____ S.S. #: _____
Blood Type: _____ Religion: _____
Recent Surgery: _____ Date: _____

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MEDICAL CONDITIONS

Check all that exist

- | | |
|--|---|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Larngectomy |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Other _____ |

ALLERGIES

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> X-Ray Dyes |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Morphine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Novocaine | |

MEDICAL INSURANCE

Company Name: _____
Policy Number: _____
Company Name: _____
Policy Number: _____
Medicaid Number: _____
Medicare Number: _____

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