SURGICAL ASSOCIATES OF PALM BEACH COUNTY/BOCACARE
PATIENT INFORMATION
PLEASE PRINT ON FORMS

Today's Date_____ **Dr. Being Seen Today**_____

First Name_____**MI**____ **Last Name**_____

Address _____**Apt. #**_____

City_____**State**_____ **Zip**_____

Home # ( )_____ **Cell # ( )**_____ **Work #( )**_____

Email: _____

Date of Birth_____**Age**_____**Social Security Number** ____-__-____

Primary Doctor_____ **Referring Doctor**_____
First and Last name First and Last name

Marital Status: ❒M ❒S ❒D ❒W **Right Handed** ❒ **Left Handed** ❒ **AMBIDEXTROUS** ❒

GENDER: ❒ **MALE** ❒ **FEMALE** **RACE:** ❒ **CAUCASIAN** ❒ **BLACK** ❒ **ASIAN** ❒**OTHER**_____

ETHNICITY: ❒ **HISPANIC OR LATINO** ❒ **NOT HISPANIC OR LATINO** ❒ **DECLINED**

Employer Name_____

How did you hear about us? ❒**Friend** ❒**Relative** ❒**Website** ❒**Dr.** ❒**Other**_____

Reason for Today's Visit_____

MEDICATIONS:

DRUG NAME (GENERIC/BRAND)	Dosage	Frequency	Aspirin: Yes ❒ No ❒
			Vitamin E: Yes ❒ No ❒
			St. John's Wort: Yes ❒ No ❒
			Prophylactic antibiotics: Yes ❒ No ❒
			Meridia: Yes ❒ No ❒

PHARMACY NAME & ADDRESS _____