CENTRAL JERSEY SURGICAL SPECIALISTS, P.A.

GENERAL, VASCULAR, LAPAROSCOPIC, ENDOVASCULAR & ONCOLOGIC SURGERY

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PLEASE PROVIDE THE FOLLOWING INFORMATION:

Reason for visit: ____

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MEDICATIONS & DOSAGE:

Name	Dosage

ALLERGIES: (Medication only)

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SMOKING: YES or NO

Patient Signature: ______________________________ **Date:** _________________________