THE SPINE & HEALTH CENTER OF MONTVALE

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TO OUR VALUED PATIENTS:

Due to changing Governmental Regulations, we are required to gather additional information for all patients. Please answer the following questions. **ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL**.

Thank you for your cooperation,

The Spine and Health Center of Montvale

Full Name: _____ **Date of Birth:** _____

Race *(select one)*:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

Height: _____

Weight: _____

Ethnicity *(select one)*:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Island
- ☐ Some other Race
- ☐ White

List of All Allergies:

_____
_____
_____
_____
_____
_____
_____

Alcohol Consumption *(select one)*:

- ☐ None
- ☐ Yes _____ # of drinks per day
- ☐ Occasional/Social

Do you Smoke Cigarettes?

- ☐ Yes
  - _____ # of Packs per Day
  - _____ # of Cigarettes per Day
- ☐ No

Did you ever smoke cigarettes?

- ☐ Yes
  - From when: _____
  - To when: _____
- ☐ No

Patient Signature _____ **Date** _____

****Please make sure you fill out this form in its entirety and return to our office.****