Ridgedale Surgery Center
14 Ridgedale Avenue, Suite 120 Cedar Knolls, NJ 07927
Phone: (973) 605-5151 Fax: (973) 605-1208

PATIENT QUESTIONNAIRE
(PLEASE PRINT)

Dear Patient,

Please complete the following questionnaire and **fax or mail to Ridgedale Surgery Center, prior to your procedure date (see below).** Please include a day time phone number where you can be reached the day before your procedure. You will receive a phone call giving instructions as to your arrival time and the time of your procedure. If you can not be reached, please call the surgery center after 11:00 am the day before your procedure.

Patient Name: _____ Date of Procedure:_____

Surgeon: _____Procedure:_____

Tel. No. of where I can be reached the day before my procedure:_____

If unavailable, can we leave a message on your answering machine: □ Yes □ No

MEDICAL HISTORY

Brief History of Current Illness: _____

Please circle any of the following which apply to you:

High blood pressure	Angina/chest pain	Heart attack	Pacemaker/Implanted Defibrillator
Valve Prolapse/Prosthesis	Heart Failure/CHF	Irregular heart beat	Diabetes - insulin or oral meds
High Cholesterol	Asthma	Emphysema/COPD	Cough/Shortness of Breath
Chronic Bronchitis	Sleep Apnea	Seizure disorder	Neurologic disorder
Stroke/TIA	Hiatal Hernia/Reflux	Ulcers/Colitis	Kidney Disease
Hepatitis/Liver Disorder	Thyroid disorder	Muscle/Joint disorder	Cancer: _____
Genitourinary/Incontinence	Clotting disorder	Anemia	Other: _____

Please list all previous surgeries:
_____
_____
_____
_____

List any Allergies:
_____
_____
_____

Social History:
Do you smoke? □ no □ yes
Do you drink alcohol? □ no □ yes
if yes, how much? _____

Medications: Please list: **Also bring a complete list of your current medications and dosages with you to your appointment.**
_____
_____
_____
_____

Do you take aspirin or blood thinners □ no □ yes
If yes, when was last dose? _____

Have you or any blood relatives had any adverse reactions to anesthesia? □ no □ yes If yes, please explain_____
_____

Patient Signature: _____ **Date**:_____

INSURANCE INFORMATION

Primary Insurance_____

ID Number_____ Group Number_____

Subscriber_____ Birth date_____ SS#_____

Employer:_____ Relationship to patient: □Self □Spouse □Parent □Other_____

IF YOUR INSURANCE CHANGES BETWEEN SCHEDULING AND THE DATE OF PROCEDURE, YOU MUST NOTIFY US AS SOON AS POSSIBLE SO WE MAY OBTAIN THE PROPER REFERRALS AND PRECERTIFICATION NECESSARY.

Name of person completing this form _____ Relationship to patient: □Self □Other_____