

# CENTRAL JERSEY SURGICAL SPECIALISTS

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## PLEASE PROVIDE THE FOLLOWING INFORMATION:

Reason for visit: \_\_\_\_\_

### MEDICATIONS & DOSAGE:

| Name | Dosage |
|------|--------|
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### ALLERGIES: (Medication only)

\_\_\_\_\_  
\_\_\_\_\_

### SMOKING: YES or NO

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_