THE SPINE & HEALTH CENTER OF NEW JERSEY

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.

Name: _____

Date of Birth: _____

Race (select one):
Hispanic or Latino: _____
Not Hispanic or Latino: _____
Decline to answer: _____

Ethnicity: (select one)
American Indian or Alaska Native: _____
Asian: _____
Black or African American: _____
Native Hawaiian or other Pacific Island: _____
Other Race: _____
White: _____

Height: _____

Weight: _____

Allergies: _____
_____

Alcohol Consumption (select one):
None: _____
Yes: _____ # of drinks per day: _____
Occasional/Social: _____

Do You Smoke Cigarettes?:
Yes: _____ # packs per day: _____ #of cigarettes per day: _____
No: _____

Did You Ever Smoke Cigarettes?:
If Yes: _____ from when: _____ to when: _____
No: _____

PATIENT SIGNATURE: _____ **DATE:** _____