DR. CAMERON SIKAVI, MD

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First Name _____ **Middle Name / MI** _____ **Last Name** _____

Patient Address Line 1 _____ **Patient Address Line 2** _____

City _____ **State** _____ **Zip** _____

Date of Birth _____ **Age:** _____ **Social Security Number** _____

Email _____ **Work Phone** _____ **Cell Phone** _____

Professional Title _____

How were you referred to our office? _____ **Who is your primary care physician?** _____

Primary Insurance Information

Primary Insurance Name _____ **Primary Subscriber ID** _____ **Primary Group No.** _____

Are you the subscriber on the policy? If not, who is? _____

Secondary Insurance Name _____ **Secondary Subscriber ID** _____

Emergency Contact Name _____ **Emergency Contact Relationship to Patient** _____ **Emergency Contact Cell Phone** _____

What is your preferred pharmacy: _____ **Pharmacy Address:** _____ **Telephone No:** _____

Reason you are being seen: _____

Personal Medical History (please check all that apply):

Heart Disease ◯ Yes ◯ No

Lung Disease ◯ Yes ◯ No

Artificial/Prosthetic Heart Valve ◯ Yes ◯ No

Liver Disease/Hepatitis ◯ Yes ◯ No

Kidney Disease ◯ Yes ◯ No

Diabetes ◯ Yes ◯ No

Cancer ◯ Yes ◯ No

Seizure Disorder ◯ Yes ◯ No

High Blood Pressure / Hypertension ◯ Yes ◯ No

Bleeding Disorder ◯ Yes ◯ No

Thyroid Disease ◯ Yes ◯ No

Acid Reflux/GERD/Peptic ulcer disease ◯ Yes ◯ No

Constipation ◯ Yes ◯ No

Other conditions ◯ Yes ◯ No

Comments

Surgical History (please list all operations that you have had, including the year):

Family History (Please indicate if you have had any relatives with a history of colon cancer, colon polyps, stomach cancer, other cancers, Crohn's disease, or Ulcerative Colitis):

Please list all medications you are currently taking (including over the counter medications):

Do you have any allergies to medications? If so, what medication and what is the allergy?
