CHCT TEST FORM INFORMATION
(MHG 101)

Date: ______________________

Referring Physician: ____
(Please send letter of referral)

Patients Full Name at Birth: __________________________________

Date of Birth: ____

Race: ________ Sex: ________ Religion: _______________________

SSN: ____

INSURANCE

Insurance Company: ______________________________________

Address: ____

Tel Number: ____

Mailing Address:____

City, State, Zip: ____

Tel: Home ______________ Work _____________Cell__________

E-Mail ____

Marital Status and Name: ___________________________________

Policy Number: ____

Groups Number: ____

Referring Physician: ____

Physician Tel: ______________________________________

Address: ____

Please send a referral letter from your primary physician
Please Send A Copy Of Your Insurance Card
Reason for referral:

DEMOGRAPHICS **Hospital medical records sent?**

Sex: ___________ Weight: ___________ Height: ________________

Race: __________ Body Build: ______________________________

FAMILY HISTORY

Mothers Name (incl. maiden): ____________________________

Address: ____

Home Tel: ____

Work Tel: ____

Fathers Name: ____

Address: ____

Home Tel: ____

Work Tel: ____

Has anyone in your family died or had an unusual reaction to anesthesia during surgery? If so, explain.

Does anyone in your family have a neurological or muscular disease? If so, explain.

What type of anesthesia was used during surgery?

What are the dates of the previous surgery?

How many children do you have? _________________________

Name(s) and age(s):

How many brothers and sisters do you have?
____

Name(s) and age(s)

Are you taking any **blood thinner medication***? ________________

If so, what are you taking? __________________________________

*Please discontinue use of any blood thinner medication one week prior to surgery. No food or drink after midnight before surgery.