Juan C. Baez MD LLC

Name:_____ Social Security: _____

Date of Birth: _____ Phone Number: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Occupation: _____

Email: _____

Race: Asian Black/African American Hispanic White Other: _____

Preferred Language: English Spanish

Reason For Visit:_____

Medical History: _____

Surgical History: _____

Family Medical History: _____

Allergies:_____

Medications (doses/frequency): _____

_____

_____

*****Attach insurance card to this form**

Copay Amount (if applicable): _____

Referred by: _____