Howard Leitner & Perlmutter
UROLOGIC ASSOCIATES

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Cover Sheet

Name: _____
Address: _____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Fax:_____
Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____
Reason for visit (optional):_____
Who is you Primary Physician?_____
Address:_____
Any changes/updates to your Pharmacy? Yes No
If Yes:_____
Any changes/updates to your medical/surgical/social history? Yes No
If Yes:_____
Current Height? _____ Current Weight?_____
Allergies to Medications: _____
Reaction:_____
Allergies to (circle): Iodine Shellfish IV Contrast Dye Latex
Adhesive Tape Betadine Chloroprep Other:_____

Medications	Strength	#Doses/day	Start Date	Refills