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PatientPre Surgery Clearance Information

If you are a new patient, please fill the New Patient Registration Form in addition to providing the following information.

- **Surgeon Information**

  Name of Surgeon: _____

  Office Phone: _____

  Office Fax: _____

- **Surgical Coordinator/Nurse of Surgeon**

  Name : _____

  Phone: _____

  Fax: _____

- **Surgery Center/Hospital Details**

  Name of Surgery Center/Hospital : _____

  Contact Name: _____

  Contact Phone: _____

  Contact Fax: _____

- **Surgery Details**

  Date of Surgery: _____

  Type of surgery: _____

  _____

  _____

  Type of planned anesthesia: _____

  _____