Marone Wellness

Simpsonville, SC 29681

Certification Information

Dear Patient: The US Government is now requiring that we supply them with the following information.

Name _____ Date of Birth _____ Pt. Number _____

PRESCRIBED MEDICATIONS

Please check here if NOT taking ANY PRESCRIBED MEDICATION. _____

Medication	**# of Refills**	**# of Pills**	**Strength**	**Dose Form**	**MD Instructions**

Are you allergic to ANY medicines?

Check here if you DO NOT have any medicinal allergies: _____

Drug (i.e. Penicillin)	**Symptoms (i.e. headache)**

Please Circle:

Preferred Language: English Spanish German Other

Smoking Status: Smoke Every Day Smoke Some Days Former Smoker Never

Ethnicity/Race: Caucasian/White Hispanic/Latino Black/African American Other

If the Government needs to contact you, how would you like this Confidential Communication to be received? Prefer: Phone Call or Text Message

Phone #: _____

Email: _____

Have you been diagnosed with: (Please Circle) Asthma or Diabetes

OFFICE USE ONLY

Blood Pressure _____/_____ Height _____ Weight _____

Entered by _____ Date/Time: _____