PATIENT DEMOGRAPHICS

ST. GEORGE SURGICAL CENTER

rev. 7/2025

Surgeon_____ Today's Date_____

Phone _____ Contact _____

Patient's Name_____ Birthdate_____

Address_____

Contact #_____ If minor, Parent's Name _____

email _____

Gender: Female _____ Male _____

Does the patient have a chronic infection? (MRSA, VRSA, VRE, etc.) Yes_____ No_____

Diabetic? Yes__No___ Latex Allergy? Yes___No___ Fam. History of Malignant Hyperthermia? Yes___ No___

Has this patient had a prior surgery at St George Surgical Center? • Yes • No • Unknown

Send PRIOR CONSULTATION AND MEDICAL TESTS: To conniem@sgsc.net

Send IMAGING and MRI DISKS to: SGSC / Attn: Connie / 676 So. Bluff St. George, UT 84770

Will LABS be required? (circle) Y or N (NOTE: LABS ARE NOT A PART OF THE SURGERY BUNDLED RATE)

Surgery _____ Website Price $_____

Referral Source:_____

Ht:_____WT:_____BMI:_____Notes:_____

_____

Diagnosis_____

PROPOSED DATE FOR SURGERY _____

Inquire about the St. George, UT

List of Hotels