Vital Statistics Log

Patient Name: _____ Insurance Name: _____

Insurance Phone No. _____ Insurance No. _____

Primary Care Provider: _____ Provider ID No. _____

Doctor Phone No. _____ Doctor Address: _____

Dentist Name: _____ Dentist Phone No. _____

Dentist Address: _____ SSN: _____

Date of Birth: _____ Age: _____ Blood Type: _____

Weight: _____ Height: _____ Sex: _____ Race: _____

Blood Pressure: _____ Cholesterol: _____ Heart Rate: _____

Notes:

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Notes:

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