Central California Surgery

No Smoking Attestation

Completion of this form by your Primary Care Physician is required by your insurance company prior to surgery authorization. Once patient is scheduled for surgery they will receive a History & Physical from our office.

Patient Name:_____**DOB:** _____

The patient named above has no history of smoking in the last 6 months.

_____

Primary Care Physician Name (Printed) **Phone Number**

_____

Address

_____

Primary Care Physician Signature **Date**