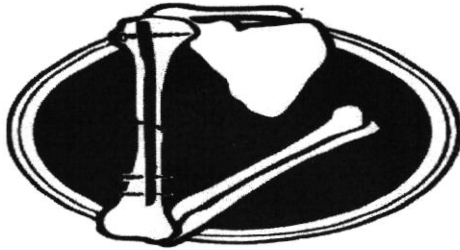


SILVER STATE ORTHOPEDICS

WWW.SILVERSTATEORTHO.COM

3196 S. Maryland Parkway #112 Las Vegas, NV 89109

Phone: (702) 216-2670 Fax: (702) 826-4845

Patient Information

Last: ______________ First: __________________ MI: ____ Social Security: ________________

Street Address: ______________________________ Apt: _____ City: ______________ Zip: ______

DOB: ____________ Age: ___________ Marital Status: S__ M__ D__ W__ Sex: __________

Telephone: (____) ________________ Cell: (___) _________________ Email: _________________

Employer: _______________________ Employer's Address: ________________________________

Occupation: _________________________ Work Phone (___) ______________________________

Emergency Contact: __________________________ Telephone (___) _______________________

Guarantor Information (Insured Person)

Last: ______________ First: __________________ MI: ____ Social Security: ________________

Street Address: ______________________________ Apt: _____ City: ______________ Zip: ______

DOB: __________ Sex: ________ Relationship: _______________Telephone: (____) _____________

Employer: ______________________ Work Phone (___) ______________________________

Name(s) of Insurance 1 _____________________________ 2 ______________________________

Additional Information

Accident: Yes____ No: ____ DOI: ______ Work Related: ____ Auto Accident: ____ Atty retained: ______

Describe How Injured: ____

Body Part Injured: ________________________________ Check One: (RIGHT) _____ (LEFT) _____

Do you have insurance: YES __ NO __ Thru Employer: YES __ NO __ Private Insurance: YES ___ NO _

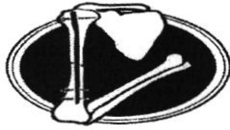
Name(s) of Insurance 1 _____________________________ 2 ______________________________

Were you seen in Emergency Room: YES _____ NO _____ Where: _____________ When: _________

Were X-rays taken: YES _____ NO _____ Where: ____________________________ When: _______

I hereby sign to David A. Silverberg, M.D., all benefits for surgical and medical payable under the attached policy and/or policies. I also authorize release of information under the same policy. I understand I am financially responsible for any and all charges not covered/or denied by any insurance.

Signed ____ Date ____________________



3196 S. Maryland Parkway, Suite 112 Las Vegas, NV 89109

Phone (702) 216-2670 Fax (702) 826-4845

Name: ______________________________ Date: ________________

Current Medications					
Medication Name	**Strength (mg)**	**Quantity**	**Refills**	**Prescribing Doctor**	**Phone Number**

** If more space is needed please feel free to continue on the back of this page

Drug Allergies	
Drug	Reaction

* ______________________________
Preferred Pharmacy Name

* ______________________________
Address

* ______________________________
City, State, Zip

* ______________________________
Phone

*Please Enter All Information

Signed ______________________________ Date ________________

3196 S. Maryland Parkway, Suite 112 Las Vegas, NV 89109
Phone (702) 216-2670 Fax (702) 826-4845

Name: ______________________________ **Date:** ____________

Please List All Physicians You Are Currently Consulting

Clinic Name ____

Address ____

Phone number (____) ____

Physician names ____

Specialty____

Clinic Name ____

Address ____

Phone number (____) ____

Physician names ____

Specialty____

Clinic Name ____

Address ____

Phone number (____) ____

Physician names ____

Specialty____

❖ *If additional space is need please continue on back of this page.*