



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 _____



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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 _____



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

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