Spine Wellness Center of Southern Nevada

# NEW PATIENT CONFIDENTIAL INFORMATION

## Contact Information

Name ______________________________________________ Date ____________________

Address ___________________________________________ City ______________________

State ______ Zip __________ Hm Phone _________________ Cell Phone ________________

Email _________________________________________________________________________

Sex _____ Marital Status _____ Date of Birth ______________ Age ____ #Children ________

SS# ___________________ Occupation _______________ Employer _____________________

Employer Address _____________________________ Employer Phone ___________________

Spouse Name ___________________________________ Spouse Employer ________________

Emergency Contact _______________________ Phone ___________

## Office Information

Who referred you to our office? ____________________________________________

Were you referred to a certain doctor in our office? _____________________________

Is your visit due to an injury? □ No □ Yes *If yes, which one*: □ Auto □ Work □ Other

***(If this visit is due to a work or auto injury, please see the receptionist for a special injury form)***

List other doctors you use for your health care: __________________________________

Previous Chiropractor(s): __________________________________________________

List any surgeries with dates: ______________________________________________

Note any auto accidents with dates: __________________________________________

## Insurance Information

Do you have insurance? □ Yes □ No Company _________________________________

I.D. # __________________________ Policy Group # ________________________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Spine Wellness Center extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Spine Wellness Center and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____________________________________________

3085 E Russell Rd, Ste E
Las Vegas, NV 89120
T: 702-433-8333
F: 702-433-4632

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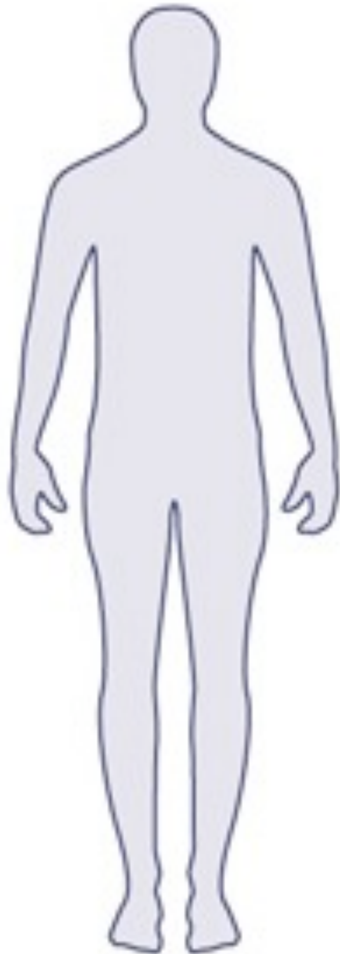
# PAIN DRAWING

Patient Name: ______________________________________
Date: ______________________________________

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

**A =** Ache **B =** Burning **N =** Numbness **P =** Pins & Needles **S =** Stabbing

R L

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Patient Signature: ______________________________________
Date: ______________________________________

**SUBJECTIVE and OBJECTIVE NUMERICAL OUTCOME MEASURE ASSESSMENT**

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