DESERT INSTITUTE OF SPINE CARE

Contact us

702-630-3472

intake@disclv.com

9339 W. Sunset Rd.
#100 Las Vegas, NV 89148

www.disclv.com

Patient Information

Last Name:

First Name:

Middle Name:

Sex:

Male:

Female:

Date of Birth:

Social Security Number:

Ethnicity:

Decline:

Race:

Decline:

Address:

City

State

Zip code

Street

Phone: Cell

Phone: Home

Employer Phone:

Employer Name:

Emergency Contact:

Relationship:

Phone:

Notice of Privacy Information Practices of Andrew M. Cash MD policy regarding minimum necessary uses and disclosures of protected health information. I accept or I decline to receive a copy of privacy practices.

Patient Signature:_____ Date:_____

By signing this form, I hereby consent to and authorize medical treatment, tests, and procedures performed in the office that the physician deems advisable and necessary based on his/her judgment.

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Primary Insurance

Primary Insurance:

Insured Name:

Insured DOB:

Insured Social Security #:

Policy ID#

Group:

Print Name:

Signature:

If an attorney represents you, what is:

Attorney Name:

Law Firm:

I understand by using my private health insurance, although I have an Attorney, I will be responsible for payment at time of service and any charges not covered by m insurance.

Signature:

LIEN ONLY

I DO NOT have health insurance. Therefore, please bill all my office visits and/or charges directly to the attorney listed below:

Attorney Name:

Law Firm:

Date of injury:

Print Your Name:

Signature:

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Patient Name: Date: DOB:

What is your chief complaint?

Circle any you have:
Headache; depression; anxiety; insomnia; Lingering memories of the accident, Fever; Chills; Night sweats.
Weight Loss, Uncontrollable bowel movements, Uncontrollable urination; Pain interferes with sex; Impotence.

List current Medications:

List allergies:

List prior surgeries:

Circle any that you do and write how much:

tobacco alcohol recreational drugs

Height: Weight:

On average the neck pain is ____ / 10 ____ / 10 at its worst. What makes the pain worse _____

(Right after the accident)

Neck Pain CURRENTLY ____ / 10.

(Right after the accident)

On average the back pain is ____ / 10 ____ / 10 at its worst. What makes the pain worse _____

(Right after the accident)

Back Pain CURRENTLY ____ / 10.

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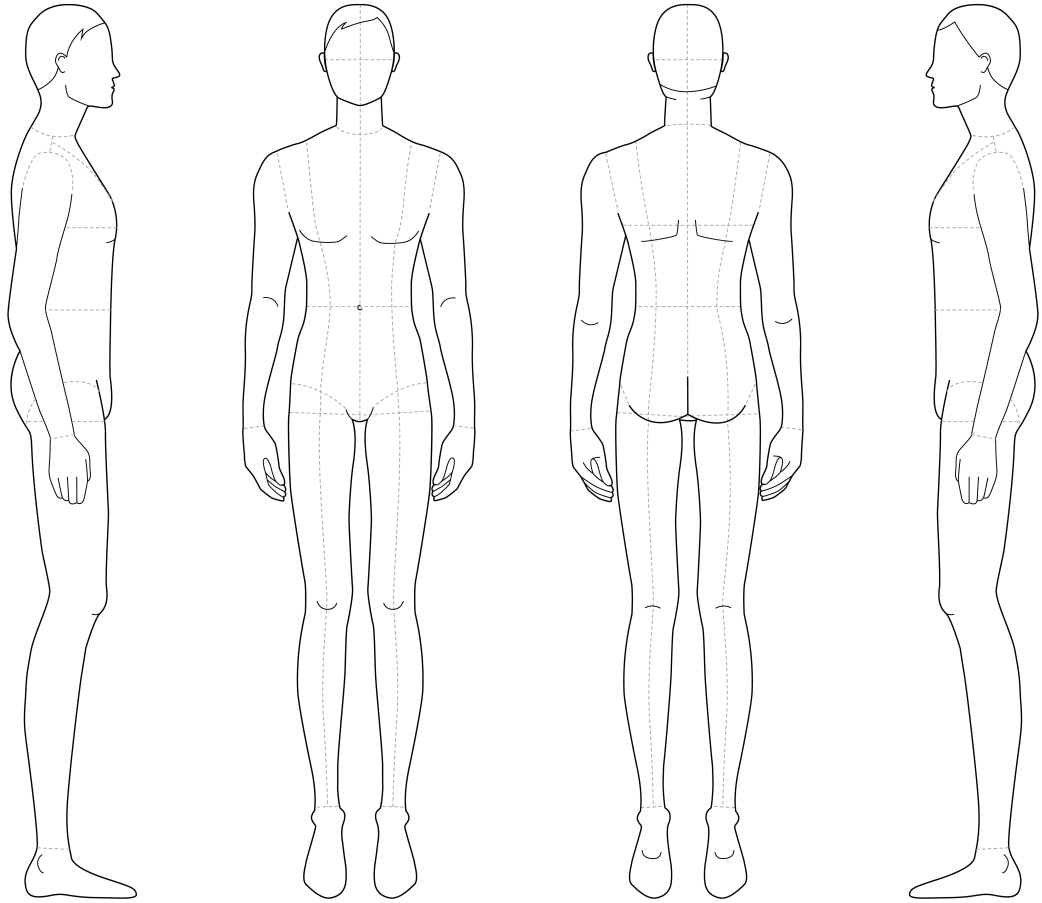
If having pain, numbness, or tingling, in arms and legs please circle that apply:

Arms: R L Legs: R L



Circle any treatment you had: chiropractic, MRI, injections, other:_____

If so, where were the procedures done?_____

_____

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Patient Name: Date:

Date of Accident/Injury:

MOTOR VEHICLE ACCIDENT:
Were you? Rear-end/ Head on/ T-boned / Side swiped (Driver's or Passenger's side)
Were you the Driver? Yes/No, if passenger, which seat? front / rear // left side / right side
What kind of vehicle were you in? SUV Compact Mid-size Motorcycle Truck / Model or Make
What were the other vehicle(s)? SUV Compact Mid-size Motorcycle Truck / Model or Make_____
Which way were you facing/turning at impact? Facing forward, Left, Right
Was the impact expected? Yes/No If yes, did you brace for impact? Yes/No
Were you wearing your Seatbelt? Yes No
Did the airbags deploy? Yes/No, if yes, did it hurt you? Yes No
Did you hit your head? Yes/No If yes, what did you hit your head on?_____
Did you hit any other body part against the vehicle? Yes/No If Yes, what body part?
Was the vehicle impacted more than once? Yes/No If yes, which part of vehicle?
After the accident how did you feel? Shaken up Adrenaline pumping Upset Confused
When did your symptoms start after the accident?_____
Please explain in your own words how the accident happened.

_____

_____

_____

If you had any PRIOR ACCIDENTS, please fill this section out:

Year	Body parts injured	What was your pain before the current accident.