

APEX MEDICAL CENTER

PATIENT INFORMATION

Name: _____ M/F Home Phone: _____

Address: _____ SSN#: _____ - _____ - _____

City/ Zip code _____ D.O.B: ____/____/____

Age: _____ Employer: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Private Insurance: Workmen's comp: Auto: Lien

Date of injury: _____ Claim #: _____

Primary Insurance: _____ Effective date: _____

Name of insured: _____ Relationship: _____ Policy number: _____

Insured D.O.B.: _____ Insured S.S. #: _____ - _____ - _____

Insurance Address _____

Insurance Phone #: _____ Adjuster Name: _____

Adjuster phone: _____ Adjuster Fax: _____

Do you have an attorney? _____ Phone: _____ Fax: _____

Secondary Insurance: _____ Effective date: _____

Name of insured: _____ Relationship: _____ Policy number: _____

Insured D.O.B.: _____ Insured S.S. #: _____ - _____ - _____

Insurance Address _____ Phone: _____

Who Referred You: _____ Yellow Page ___TV ___Newspaper ___Radio

Other Source: _____

Referral Phone #: _____ Fax: _____

Reason for referral: _____

NOTE: NEED COPIES OF INSURANCE CARDS, FRONT & BACK ATTACHED!!!

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