CENTER FOR WELLNESS & PAIN CARE OF LAS VEGAS

"where healing begins..."

# NEW PATIENT
## Non Clinical

**Your completed intake paperwork helps our Providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. If you have any questions or are unsure about how to complete any section of this form, inquire at our front desk or call (702) 476-9700.**

## Patient Information

Your Name _____

Driver's License #/State _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female

Street Address: _____

City/State/Zip: _____

Email: _____ Physical Address Same as Mailing? ❑ Yes ❑ No

If not, please list mailing address: _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other _____

## Referral

Were you referred to our clinic by another physician? If so, whom? _____

How did you hear about us? ❑ Insurance Company ❑ TV ❑ Magazine ❑ Radio ❑ PCP ❑ Family ❑ Friend

❑ Internet ❑ YouTube ❑ Facebook ❑ Twitter ❑ Telephone Message ❑ www.WellnessAndPainCare.com

❑ Other _____ ❑ Another Website _____

## Social Status

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

## Preferred Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Street Adddress: _____ City/State/Zip: _____

Do you have a Prescription Drug ID card ? ❑ Yes ❑ No Member ID #_____

RX Bin # _____ RX Group # _____

**❑ Yes ❑ No I hereby authorize The Center for Wellness and Pain Care of Las Vegas to access my electronic medication history and formulary information**

## Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Insurance Policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Policy/I.D. Number: _____ Group Number: _____

## Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Insurance policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Policy/I.D. Number: _____ Group Number: _____

## Workers Compensation Claim Information

***Complete this section only if your visit today is related to a Workers Compensation claim***

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

## Injury Claim

**Is your pain the result of a Motor Vehicle Accident or Personal Injury?** ❑ Yes ❑ No Date of Injury: _____

Law Firm: _____ Attorney Name: _____

***I certify that the above information is accurate, complete and true. I give my consent for CWPC to retrieve and review my medication history. I understand that this will become part of my medical record.***

Patient Signature : _____ Date : _____