Southern Nevada Health District

PATIENT INFORMATION (PLEASE PRINT – USE ONLY INK): ( ) Jr. ( ) Sr. ( ) Other

Patient Name: (Last) _____ (First) _____(Middle):_____

Other Name: _____ ( ) Female ( ) Male Date of Birth: _____ Age: _____

Social Security Number (if available): _____

( ) Child ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Legally Separated ( ) Living together ( ) Life Partner

Home Address: _____ City:_____ State_____ Zip Code_____

Home Phone: (____)_____ ( ) Day ( ) Evening Work Phone: (____)_____( ) Day ( ) Evening

Cell Phone: (____)_____ Do we have permission to text you? Yes__ No__ Email Address:_____

EMPLOYMENT STATUS: ( ) Student ( ) Employed ( ) Retired ( ) Self-Employed ( ) Unemployed

Employer _____ Occupation: _____

REFERRAL INFORMATION: Doctor or Clinic that sent you: _____ Phone/Fax: _____

DO YOU HAVE HEALTH INSURANCE?: ( ) Yes ( ) No Do you have other Insurance besides **MEDICAID?** ( ) Yes ( ) No

RESPONSIBLE PARTY INFORMATION: (Complete this section only if patient is a minor) ( ) Self ( ) Spouse ( ) Parent ( ) Guardian ( ) Partner

(Last Name): _____ (First): _____ (Middle): _____
Social Security #: _____ ( ) Female ( ) Male Date of Birth: _____

☐ Same As Above (If different, please complete): Address: _____ City:_____ State_____ Zip Code_____

Home Phone: (____)_____ ( ) Day ( ) Evening Work Phone: (___)_____ ( ) Day ( ) Evening
Cell phone: (____)_____ Email Address:_____

PRIMARY INSURANCE: Relation to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Name of Insured: _____ Date of Birth: _____ Social Security: _____

☐ Same As Above (If different, please complete): Address: _____ City:_____ State_____ Zip Code_____

Insured Employer Name: _____ Member Number: _____

Insurance Company Name: _____ Phone Number (___)_____ Group Number:_____

Address: _____ City: _____ State_____ Zip Code_____

SECONDARY INSURANCE: Relation to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Name of Insured: _____ Date of Birth: _____ Social Security: _____

☐ Same As Above (If different, please complete): Address: _____ City:_____ State_____ Zip Code_____

Insured Employer Name: _____ Member Number: _____

Insurance Company Name: _____ Phone Number (___)_____ Group Number:_____

Address: _____ City: _____ State_____ Zip Code_____

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I certify that the above information is correct to the best of my knowledge. I hereby authorize SOUTHERN NEVADA HEALTH DISTRICT to release any information acquired in the course of my examination/treatment to my insurance company. I agree that I am responsible for any balance due.

_____ _____ _____ _____
Patient (or Responsible Party) Signature **Date** **Web IZ#** **SNHD Initials**