JORG ROSLER, M.D.
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Phone: (702) 357-8004
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PATIENT INFORMATION
Informacion del paciente

Patient's last name (*Apellido)*: First(*Nombre)*: Middle*(Segundo nombre)*: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.			
Birth Date(*Fecha de nacimeinta)*:	Age (*Edad)*:	Social Security Number (*Seguro Social)*:	
Marital Status (circle one): Single *(Soltero/a)* Married *(Casado/a)* Divorced *Divorciado/a)* Separated *(Separado/a)* Widowed *(Viudo/a)*		Sex: ☐ M ☐ F	Home phone *(Telefono)*: ( )
Street address *(Direccion)*:			Cell phone *(Cellular)* ( )
P.O. Box:	City *(Ciudad)*:	State*(Estado)*:	Zip Code*(Codigo postal)*:
Occupation *(Ocupacion)*:	Employer *(Empleo)*:	Employer phone no.*(Telefono del empleo)*: ( )	
Referred to clinic by *(Referido por)*: ☐ Dr. ☐ Other:			

IN CASE OF EMERGENCY
En caso de emergencia

Name *(Nombre):*	Relationship to patient *(Relacion al paciente)*:	Telephone Number *(Numero de telefono)*: ( )

INSURANCE INFORMATION
Informacion de su a seguranza

Insurance Company*(Aseguranza):*	Subscriber's Name *(Nombre del suscriptor)*:	Subscriber's SSN *(Seguro social del suscriptor)*:	Birth date *(Fecha de nacimiento)*:
Policy number *(Poliza)*:	Group number *(Numero de grupo)*:	Patient's relationship to subscriber *(Relacion al paciente)*: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Occupation *(Occupacion)*:	Employer *(Empleo)*:	Employer phone number *(Telefono del empleo)*: ( )	
Name of secondary insurance *(Segunda aseguranza)*:	Subscriber's name *(Nombre del suscriptor)*:	Subscriber's SSN *(Seguro social del suscriptor)*:	Birth date *(Fecha de nacimiento)*:
Policy number *(Poliza)*:		Group number *(Numero de grupo)*:	

ATTORNEY INFORMATION
(Informacion de su abogado)

Attorney's name *(Nombre del abogado)*:	Phone Number *(Numero de telefono)*:	Date of accident *(Fecha del accidente)*:

** Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below, not to do so.

I, **DO NOT** want my health insurance billed : _____ _____ / _____ / _____
Signature Date

Please be advised that if you later decide to bill Health Insurance it will be billed from that time and date only.

PLEASE CHECK MARK HERE IF YOU ARE A: ☐ **SELF PAY/ CASH PAY**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize IPSI or my insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian signature *(Firma del paciente o guardian)* Date *(Fecha)*

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Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Date of injury (if applicable): _____ ____How did it start? _____

Have you been treated for you present problem? ☐ Yes ☐ No When?_____ By whom: _____

Indicated which of the following you have tried for you pain and if it helped:

_____Pain Clinic/Anesthesiologist _____Anti-inflammatory/Anti-Depressant
_____Trigger Point Injections _____Epidural Steroid Injection
_____Chiropractic Therapy _____Physical Therapy

How long are you able to sit/stand comfortably?_____ How far are you able to walk?_____

Circle the words that describe your pains:

ACHING	SHARP	PENETRATING	THROBBING	GNAWING
TENDER	NAGGING	SHOOTING	BURNING	UNBEARABLE
NUMBNESS	STABBING	OCCASIONAL	MISERABLE	CONTINUOUS

Do you use tobacco (smoke/chew)? ☐ Yes ☐ No If yes, how much and for how many years?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day/week:_____

Do you or have you used recreational drugs? ☐ Yes ☐ No If yes, which ones?_____

What is your occupation?_____

What is you employment status now? ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Unable to work due to pain/injury

Height:_____ Weight:_____ Have you experienced any sudden weight loss or gain?_____

Are you or could you be **Pregnant/Nursing**?_____ Date of last Period?_____

Do you have any **ALLERGIES** (ex: medication, latex gloves, tape?) ☐ Yes ☐ No If yes, please list: _____

_____

Prior Medical History (list ALL previous illness type and date): _____

_____

_____

Prior Surgical History (list previous surgeries, type and date): _____

_____

_____

List previous **Serious Injuries** (ex. Fractures with date): _____

_____

_____