Phone: 702.940.8007
Fax: 702.832.1940
www.ReleviumPain.com

Patient Information

Patient Name: ______________________________

DOB: ________________ SSN: _______________

Phone: ____________________________________

Insurance: _________________________________

Insured: ___________________________________

☐Insurance ☐Lien ☐Workers' Comp

Attorney: __________________________________

Case Manager:______________________________

Phone: ____________________________________

DOL: _____________________________________

We are located at
3975 S. Durango Drive
Suite 107
Las Vegas, NV 89147

Reason for Referral

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Diagnosis/History:

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Radiology: ☐ Yes ☐ No

If yes, Where: ______________________________

Doctor Information

Referring Physician: ___________________________

Contact: _____________________________________

Phone: ______________________________________

Fax: ____

TO OBTAIN AN APPOINTMENT

Fax this form along with medical records, relevant diagnostic reports (MRIs, X-ray, etc.) and a copy of the patient's insurance card.

Fax: 702.832.1940

Please bring this form along with your insurance cards, I.D., list of medications with dosages, and any pertinent medical records including imaging.
Co-pays are collected at time of service.