Sahara Medical Institute- 5781 W. Sahara Avenue. Suite 500. Las Vegas, NV 89146

PATIENT INFORMATION

Patient's Name: _____ DOB:

_____SS#:_____

Father's Name:

_____DOB:_____SS#_____

Home Address: _____City, State, Zip_____

Home phone: _____Cell phone: _____Work phone: _____

Employer Name: _____Employer Address: _____

Email address: _____

Mother's Name: _____DOB:

_____SS#_____

Home Address: **(if different from father)**

_____City, State, Zip _ _____

Home phone: _____Cell phone: _____Work phone: _____

Employer Name: _____Employer Address: _____

Email address: _____

Primary Insurance Holder's Name:

_____

Primary Insurance: _____ ___ Insurance ID: _ _____

Group #: _____ _____Insurance Contact #: _____

Insurance Address: _____City, State, Zip_____

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Secondary Insurance Holder's Name:

_____

Insurance: _____ ___ Insurance ID: _ _____

Group #: _____ ____ Insurance Contact #: _____

Insurance Address: _____City, State, Zip_____

Name of Siblings: _____

_____

_____

Name of person caring for child (if different from

PARENT):_____

Refered By: _____

Birth History:

Hospital: _____ Obstetrician: _____

Type of Delivery: _____ Complications: _____

Type of feeding: _____Birth Weight: _____ Discharge weight: _____

Blood Type: _____

Family History:

Anemia: _____Asthma:____ _____ Birth Defect:_____

Cancer: _____ Convulsions: _____ Diabetes: _____

Heart Disease: _____ Kidney Disease: _____Learning Problem:_____

Tuberculosis: _____Vision, Speech, Hearing Problem: _____

Other: _____

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Allergies

to:_____

Date: _____ **Signature of Parent or**

Guardian:_____