IMS
INTERNAL MEDICINE SPECIALISTS

Thomas A. Alfreda. Jr., MBA., D.O.
Babak Ghadishah, D.O.
Gary J. Grossman, M.D.
Robert A. Whipple, M.D.
Misako McLeod, DPM
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David H. Rosenstein, M.D.

201 North Buffalo Drive
Las Vegas, Nevada 89145-0373

Telephone: 702.242.2737
Fax: 702.255.3170

www.IMSDoctors.com

PATIENT INFORMATION

Name: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Referring Doctor: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone _____ Email: _____

Preferred method of communication? _____

Home phone: Okay to leave a message? ☐ YES ☐ NO

Cell phone: Okay to leave a message? ☐ YES ☐ NO

Email: _____ Other:

GUARANTOR INFORMATION†

Name of Responsible Party: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Relationship to Responsible Party: ☐ Dependent ☐ Spouse ☐ Other: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

†If the primary insurance is through the parent/spouse, please complete this using their information

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EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: _____ Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Certificate Number: _____ Certificate Number: _____

Group Number: _____ Group Number: _____

Group Name: _____ Group Name: _____

Co-pay: $_____ Co-pay: $ _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

How did you hear about us? _____

☐ Friend: Who shall we thank? _____

☐ Doctor: Who shall we thank? _____

☐ Hospital ☐ Advertisement ☐ Website Which? _____

☐ ZocDoc: _____ ☐ Other: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize the release or medical or other information as necessary to process health insurance claims. I also request payment of benefits to my Provider when he/she accepts assignment.

Signature: _____ Date: _____