3035 W. Horizon Ridge Pkwy, Ste 120
Henderson, NV 89052
T: 702-666-0463 F: 702-666-0455

General Patient Information

Patient Name ______________________ DOB ___ /__ /_____Age________

Social Security #__________________________ Height_______ Weight _________

Address _______________________City____________ State ______ Zip____________

Email Address____

Cell Phone __________________ Home Phone______________________________

Occupation _______________ Employer ______________________________________

Emergency Contact ____________________ Phone number _________________________

PLEASE CIRCLE ALL THAT APPLY

High Blood Pressure	**Cough**	**Seizure**	**Cancer**
Heart Murmur	**Short of Breath**	**Stroke**	**Hepatitis A/B/C**
Arrhythmia	**Asthma**	**Migraines**	**Renal Disease**
Heart Attack	**CPAP/ Oxygen**	**Numbness**	**Kidney Stones**
Coronary Artery Disease		**Tingling**	
Anxiety/Depression	**Anemia**	**Gout/Arthritis**	**Diabetes**
Suicide Attempt	**Blood clots**	**Back Pain**	**Hypothyroid (LOW)**
Drug dependency	**Phlebitis**	**Paralysis**	**Hyperthyroid (HIGH)**
	Blood Transfusion	**Weakness**	**HIV/AIDS**

Alcohol Use (Frequency) ___________ Tobacco Use (Frequency) ____________________

Drug Allergies (Please list and include reaction) ________________________________

Family Medical History ____

Tim Tollestrup MD
PERIPHERAL NERVE SURGERY

Please list all prior surgeries: Orthopedic, Spine, or peripheral nerve surgery:

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____
____
____
____

Please list all of your prescription medications and doses.

____
____
____
____

Please list the names of your Physicians if applicable.

Primary Care Physician: ___________________________________

Pain Management Physician: ________________________________

Cardiologist: ____

I, the patient, certify that the information on this form is true to the best of my knowledge. I hereby authorize the release of all applicable medical information,
Including without limitation copies of all records and test results produced to the designated attending, referral and/or follow up physicians and such, other healthcare practitioners or organizations who/which will be providing subsequent monitoring, care or treatment in connection with care provided by Tim Tollestrup, M.D. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare to be paid directly to Tim Tollestrup, M.D. I further agree that a photocopy or scanned copy of this document is to be considered as valid as an original.

Patient Signature: ___________________________________
Date____