

DPM

DIMURO PAIN MANAGEMENT

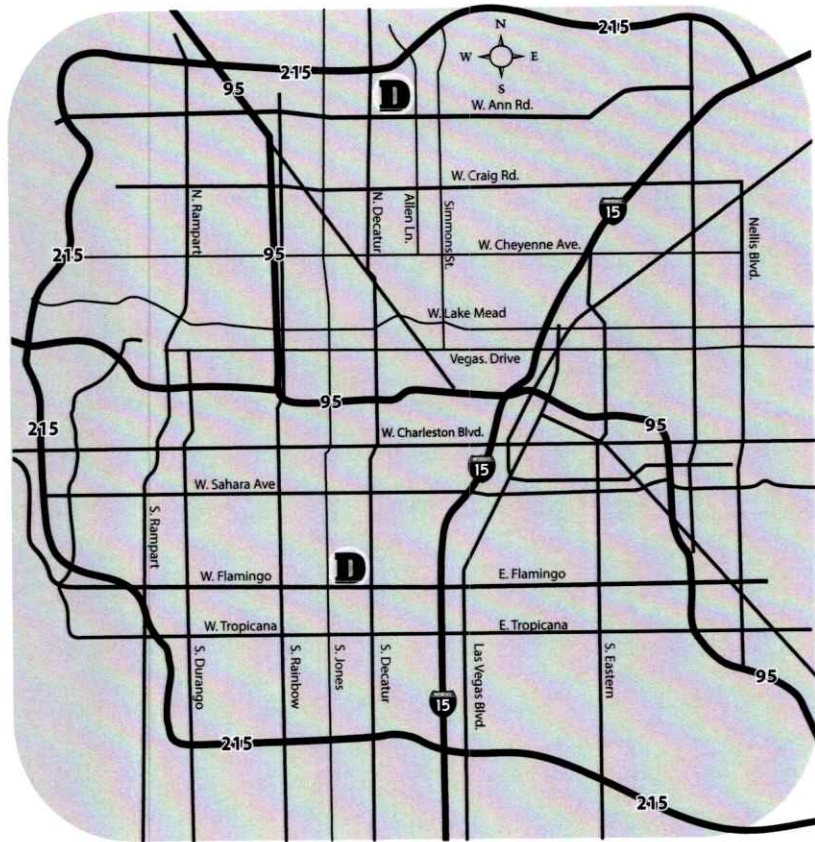
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Patient Information

Patient Name: _____

DOB: _____ SS#: _____

Phone: () _____

Insurance Co.: _____

Phone: () _____

Insured: _____ SS#: _____

Attorney: _____

Case Manager: _____

Phone: () _____

DOL: _____ MVA P.L.

Reason for Referral

Diagnosis / History: _____

Radiology: Yes No

If Yes, Where? _____

Referral Doctor Information

Referring Physician: _____

Phone: () _____

Contact Person: _____

Fax: () _____

To obtain an appointment; fax this form, your insurance cards, I.D., a list of your medications with dosages and all relevant diagnostic reports (MRI, X-Rays, etc.) to DiMuro Pain Management 702-747-4667. You may also call to schedule an appointment. Thank you!

Please bring these items with you to your appointment

* Denotes facility accredited by AAAHC