Patient Information

520 Superior Ave St. 220
Newport Beach, CA 92663
(949) 642-2333 Fax (949) 548-9456

_____ Gary Carlson, M.D. _____ Gregory Katz, M.D.

PATIENT INFORMATION:

Date:_____

Name:_____ Sex: M F Marital Status: S M D W
Last First MI

Address:_____City:_____State: _____Zip: _____
(No P.O. Boxes are acceptable)
Home Phone: ( )_____Drivers Lic#: _____ S.S. #: _____-_____-_____
Cell phone: ( ) _____
Date of Birth: _____ Age: _____ Allergies & Reactions _____
Employer: _____Work Phone: ( )_____ Occupation:_____
Address: _____ City: _____ State: _____ Zip: _____

SPOUSE'S INFORMATION:

Name: _____ S.S.#: _____-_____-_____ Date of Birth: _____
Last First MI
Employer: _____ Work Phone ( )_____Occupation: _____
Address:_____City: _____State: _____Zip: _____

INSURANCE INFORMATION:

Primary Insurance Company Name:_____Name of Insured:_____

Secondary Insurance Company Name: _____ Name of Insured: _____

REFERRAL INFORMATION:

Referred by: Physician_____ Other: _____

EMERGENCY CONTACT: (Of someone NOT living with you)

Name of Contact:_____ Relationship: _____
Address: _____City: _____State: _____Zip: _____
Home Phone:( ) _____ Work Phone: ( ) _____

ADVANCE DIRECTIVES: If you need information or inquiring about advance directives (Durable Power of Attorney for Health Care Natural Death Act Declaration or Living Will) please call the member services department of your health plan.

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, FINANCIAL LIABILITY:

I hereby assign my insurance benefits to be made directly to Newport Medicine Group and any assisting physicians, for services rendered.
I hereby attest that I am an eligible member of the provided insurance company and understand that I am responsible for knowing my benefits coverage. I will be financially responsible for all charges that are NOT covered by my Insurance Company. I also hereby authorize Newport Medicine Group to release all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an aggreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency cost, and any other fees related to you bill. I hereby acknowledge that I have read, understand, and agree to hereby give consent for treatment.

_____
Patient's Signature Date

PHARMACY INFORMATION:

Name of Pharmacy: _____
Address: _____
City State Zip
Phone #: (____)_____
Fax #: (____)_____