

Newport Orthopedic Institute

Your Doctor has requested that this form be completed.

Please Print

Please Print

Doctor: _____

[] Huntington Beach [] Newport Beach

PATIENT INFORMATION

Name: _____

Patient ID #: _____ Sex: []M []F

Address: _____

Date of Birth: _____ Age: _____

City,State,Zip: _____

Social Security #: _____

Email: _____

Marital Status: []Married []Single []Divorced

Phone: _____ []Home []Work []Other

Primary Physician: _____

Phone: _____ []Home []Work []Other

Referral Source: _____

Employer: _____

Referring Physician: _____

Phone: _____

Was this an injury? Yes No

Date of Injury _____

Where did injury occur? Work _____ Auto _____ Home _____ School _____ Other: (Specify) _____

Work _____ Auto _____ Home _____ School _____ Other: (Specify) _____

Work _____ Auto _____ Home _____ School _____ Other: (Specify) _____

Work _____ Auto _____ Home _____ School _____ Other: (Specify) _____

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Work _____ Auto _____ Home _____ School _____ Other: (Specify) _____

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[] Same as Patient [] Same as Guarantor [] Other

Insured Party: _____

Relationship to Patient: _____

Insurance Carrier: _____

Social Security #: _____

Claims Address: _____

Insured ID / Cert. #: _____

City,State,Zip: _____

Policy Group: _____

Phone: _____

Date of Birth: _____

Phone: _____

Phone: _____

SECONDARY INSURANCE

[] Same as Patient [] Same as Guarantor [] Other

Insured Party: _____

Relationship to Patient: _____

Company: _____

Social Security #: _____

Address: _____

Insured ID / Cert. #: _____

City,State,Zip: _____

Policy Group: _____

Phone: _____

Date of Birth: _____

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I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Newport Orthopedic Institute, A Medical Group, Inc. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Newport Orthopedic Institute, A Medical Group, Inc. in the collection of amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Newport Orthopedic Institute, A Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release if all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party payer or because of pending legal claims.

Date: _____ Responsible Party: _____