NEWPORT
FAMILY MEDICINE

520 Superior Avenue, Suite 360
Newport Beach, CA 92663
Phone: (949) 644-1025

PATIENT INFORMATION SHEET (ADULT)

PATIENT NAME: LAST ☐ Mr. ☐ Mrs. ☐ Ms.	FIRST	MIDDLE INITIAL	DATE OF BIRTH:	
HOME ADDRESS:				
CITY:	STATE:	ZIP CODE:	EMAIL:	
EMPLOYER:	OCCUPATION:		YEARS EMPLOYED:	
HOME PHONE:	BUS. PHONE:		CELL PHONE:	
DRIVER'S LICENSE:	SOC. SEC. NO:			
SEX: ☐ M ☐ F	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	REFERRED BY:		
SPOUSE'S NAME: LAST	FIRST	MIDDLE INITIAL	DATE OF BIRTH:	SOC. SEC. NO:
SPOUSE'S EMPLOYER:	YEARS EMPLOYED:	BUS. PHONE:		
CHILDREN LIVING AT HOME: (names & birth dates)				
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:	PHONE:			

INSURANCE

PRIMARY INSURANCE CARRIER NAME:	POLICY ID#:	GROUP #:	
INSURED'S NAME: LAST	FIRST	MIDDLE INITIAL	
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:		
SECONDARY INSURANCE CARRIER NAME:	POLICY ID #:	GROUP #:	
INSURED'S NAME: LAST	FIRST	MIDDLE INITIAL	
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:		

PATIENT ELIGIBILITY WAIVER

I HEREBY ATTEST THAT I AM AN ELIGIBLE MEMBER OF THE HEALTH PLAN NOTED ABOVE. I AGREE THAT SHOULD IT BE DETERMINED THAT I AM INELIGIBLE FOR SERVICES RENDERED BY NEWPORT FAMILY MEDICINE OR BY ANOTHER FACILITY OR PHYSICIAN AS THE RESULT OF A NEWPORT FAMILY MEDICINE PRIMARY CARE DIRECT REFERRAL, I WILL BE RESPONSIBLE FOR PAYMENT TO NEWPORT FAMILY MEDICINE OR ITS AGENT FOR THOSE SERVICES DEEMED INELIGIBLE OR NOT COVERED.
I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN.
I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME TO SECURE PAYMENT FROM MY INSURANCE COMPANIES.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

In order to control costs of billing we request charges for office visits and/or co-payments be paid at the conclusion of each visit.

Signed: _____ Date: _____