Newport Center for Special Surgery

Registration

Date:___________
Name:_______________________________
Date of birth: ___/___/___
Drivers License Number:_________________

Primary language:____________________
Social Security #:_____________________
Marital Status___________
Spouses Name:_______________________

Home address:___________________________City:_________________Zip:_________
Home phone number:___________________ Cell phone number:______________________
Employer:______________________________ Fax Number___________________________
Work address:______________________________City:________________Zip:_________
Work phone number:____________________ E-Mail____________________________

Primary Insurance Company:_______________________ Group ID #:________________
Plan/ID#:_________________________ Authorization Phone Number:________________
Insured's name:____________________ Insured's date of birth: ___/___/___

Secondary Insurance Company:_____________________ Group ID #:________________
Plan/ID#:_________________________ Authorization Phone Number:________________

Person to contact in Emergency:______________________ Relationship:_____________
Phone number:_________________ Pharmacy Name:_____________ Phone:____________

Primary Physician

Name______________________________ Phone Number_________________________
Address____

Referral Physician

Name______________________________ Phone Number_________________________
Address____

Other Physician

Name______________________________ Phone Number_________________________
Address____

How did you become aware of the Newport Center for Special Surgery? Location/ Web/Phone Book/ Brochure/ TV Ad/ News Article/ News Ad in ______________ paper/ Referred by: Dr./ Family/ Other patient: ___________________________________

Who may we send copies of your medical records to: ____
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I hereby authorize the Newport Center for Special Surgery to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the facility in accordance with California Insurance Code, Section 10133. 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 I am financially responsible for all charges whether or not paid by said insurance.

Patient signature: ___________________________________ Date: __________________