NewportCare®
MEDICAL GROUP
NEWPORT BEACH - ORANGE
COSTA MESA - LONG BEACH
MISSION VIEJO - RIVERSIDE

PATIENT INFORMATION FOR MEDICAL RECORDS

Today's Date _____

Patient Name _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ City _____

State _____ Zip Code _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

☐ Married ☐ Single ☐ Divorced ☐ Widow

EMAIL ADDRESS: _____

Spouse/or Responsible Parent _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

Emergency Contact(Other than husband or wife) person not living with you

Name _____ Relationship _____

Address _____ Telephone No. _____

- Please Complete if patient is under 21 years of age or a student

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Father's Employer _____ Mother's Employer _____

Address _____ Address _____

Medical Insurance Information

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Identification No. _____ Identification No. _____

Group No. _____ Group No. _____

Phone: 949 / 491 - 9991 FAX: 949 / 612 - 9795
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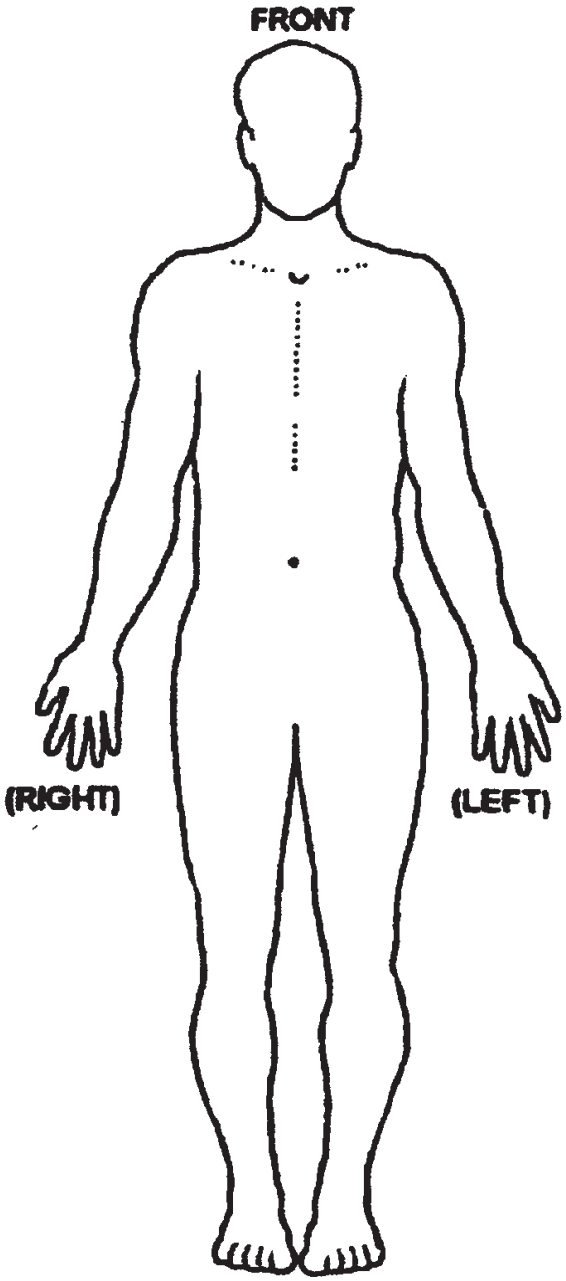
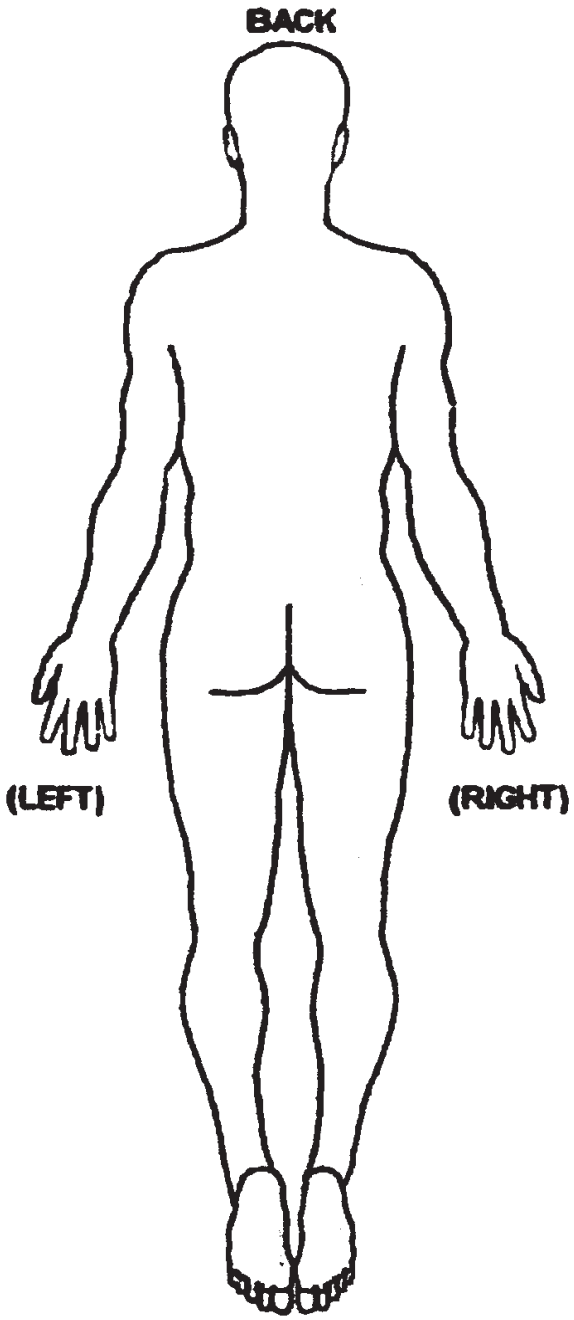
PAIN DRAWING

Please indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and to indicate where the pain is the worst.

Aching / Pain (XXXX)
Numbness / Tingling (OOOO)
Pins / Needles (: : : :)
Burning (////)
Spasm / Cramp (△△△△)





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CONSENT FORM

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. I authorize Newport Care providers and such physicians, associates, assistants, and other personnel or the hospital or medical facility chosen by him or her to perform the practice of medicine with the intention to improve my general well-being as discussed with me. At the time of treatment, I understand I can authorize any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the recommended procedure.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described to me in discussion with my provider. These risks include, yet are not limited to, the risk of bleeding, infection, pain, injury to neurovascular structures which control sensation, motor function and viability to the procedural region as well as anesthesia risks and death.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this procedure or treatment as described to me in discussion with my provider.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks as described to me in discussion with my provider.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered. I also understand no treatment is always an option if I do not want to take the above discussed procedural/treatment risks.

SECOND OPINION: I understand I can be offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue, hardware or member in accordance with customary hospital or medical facility practice.

PHOTOGRAPHY: I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

NO GUARANTEES: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

FINANCIAL POLICY: I understand that even if I have insurance, I may incur charges that are my responsibility. I understand that it is my responsibility to know my benefits and deductible information and whether or not the (PROCEDURE, DME PRODUCT, INJECTION) I am about to have is covered. If my deductible has not been met, or my insurance carrier denies this procedure, I understand that the financial responsibility is mine and that this office will bill me for services not covered or paid for by my insurance. If you are insured with a plan we are NOT contracted with, you are required to pay for the visits in full, at the time of service.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read this form thoroughly.

DATE:_____ PRINT PATIENT NAME:_____

SIGNATURE:_____

(Patient, Parent, or Legal Guardian)