Duc H. Do, M.D.,F.A.C.E.

520 Superior Ave, Suite 200 Newport Beach, CA 92663
Phone (949) 574-4114 Fax (949) 574-4144

Patient Information: **Today's Date:** ……..

Name:_____ **Sex: M F**
Last First MI

Date of Birth:_____**Age:**_____ **Marital Status: S M D W**

Address:_____ **City:**_____**State:**_____**Zip:**_____

Primary Phone: (**)**_____ **Other Phone: (** **)**_____**E-mail:**_____
(for non clinical matters)

Drivers Lic #:_____ **S.S.#:**_____ **ANY ALLERGIES:**_____ _____ **(or NONE)**

Employer:_____**Work Phone: (** **)**_____ **Occupation:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Spouse's Information:

Name:_____**S.S.#:**_____**Date of Birth:**_____

Employer:_____ **Work Phone:(** **)**_____**Occupation:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Insurance Information:

Primary Insurance Company Name:_____**Policy Holder:**_____

Relationship to patient:_____ **SS #:**_____

Secondary Insurance Company Name:_____**Policy Holder:**_____

Relationship to patient:_____ **SS #:**_____

Referral Information:

Referred by:
Physician:_____**Other:**_____

Emergency Contact: (someone not living with you)

Name of person to 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:

I hereby assign my insurance benefits to be made directly to Dr. Do and any assisting physicians, for services rendered.

Date:_____**Signature:**_____

INSURANCE ELIGIBILITY AND FINANCIAL AGREEMENT:

I hereby attest that I am eligible member of _____**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.**

Date:_____ **Signature**_____

RELEASE OF MEDICAL RECORDS/AUTHORITY TO LEAVE MESSAGES ON ANSWERING MACHINE OR ANOTHER PERSON ANSWERING THE PHONE. (we will not leave results on machine without patient's permission) I hereby authorize Dr. Do 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.

Date:_____**Signature:**_____

ACCOUNTS MANAGEMENT:
Co-payment is due at the time service is 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 agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understood, and agree to hereby give consent for treatment.

Date:_____**Signature:**_____