460 Old Newport Blvd. Newport Beach, CA 92663
T: 949-287-6880 ▪ F: 949-258-5787

CONFIDENTIAL PATIENT INFORMATION

How did you hear about us?

☐ Patient:_____ ☐ Health Care Provider: _____ ☐ Insurance Company
☐ Newspaper ☐ Internet/Website ☐ Health Fair ☐ Other: _____

Full Name (First, Middle, Last): _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Preferred contact method: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: Select

Social Security Number: _____ Driver's License: _____

Marital Status: Select Spouse's Name: _____ # of Children: _____

Occupation: _____ Business/Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____

☐ I hereby give permission to release information related to my care to my family physician.

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship_____

IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING:

Did the injury occur at **WORK?** Select Date of Injury: _____ Time: _____

Has the injury been reported to your supervisor? Select Name of supervisor: _____

Is the injury a result of an **AUTOMOBILE ACCIDENT?** Select **OTHER?**
_____

I hereby certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief. I understand that ARC Healthcare is a professionally owned, for-profit Institution.

Patient/Guardian Signature: _____ **Date:** _____

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IF YOU WILL BE USING INSURANCE BENEFITS TO COVER SERVICES, PLEASE COMPLETE AND SIGN BELOW:

Insurance Company: _____ Group / Policy #: _____

Medicare: Select Policy Number #: _____ Effective Date: _____

Name of Primary Insured (First, Middle, Last): _____

Relationship to Insured: _____ DOB of Primary Insured: _____

I hereby instruct the insurance company listed above to pay by check made out to and mailed directly to the following address. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

ARC Healthcare
460 Old Newport Blvd. Newport Beach, CA 92663

For the professional or medical expense-benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance and/or co-pay of said professional service charges over and above this insurance payment. I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by ARC Healthcare and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case.

Patient or Insured Signature: _____ Date: _____

IF YOU DO NOT HAVE INSURANCE THAT COVERS SERVICES, PLEASE READ AND SIGN BELOW:

I hereby acknowledge that I have no insurance that covers services, and I understand that all services are payable when treatment is rendered. I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by ARC Healthcare and any emergency transporting that may be required thereto.

I further acknowledge that the fees I am paying are discounted from the usual and customary fees for services and the discounted fees I am paying are being applied to the usual fees. In the event that my insurance status changes and/or I elect to use a third party payer, the standard fees may apply.

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Deductible_____ Deductible met_____Copay/Coinsurance_____

OON Benefits: _____ OOP Max _____ Chiro/PT Benefits_____

Verified by _____Date_____