Print Form

NEWPORT LAPAROSCOPY
ANDREW SAEED IRANIHA, M.D., F.A.C.S.
Advanced Laparoscopic & General Surgery

Date/Time Field _____

Social Security Number _____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birthdate _____ Sex: _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Patients Name or Parents Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouses or Parent's Name _____ Employer _____

Whom may we thank for referring you? _____

Name & Phone # of emergency contact person not living with you? _____ # _____

When it becomes necessary to contact you by phone, please list phone number(s) where you wish us to call. May we leave messages, such as lab results, appointments, or other medical information on an answering device, or with another person who answers the phone, at that number?

☐ Yes ☐ No

RESPONSIBLE PARTY

Name of Person Responsible for this account _____ Relation to Patient _____

Address _____ Home Phone _____

Drivers License# _____ State _____ Date of Birth _____ S.S.# _____

Employer _____ Work Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____ D.O.B _____

Social Security# _____ Work Phone _____

Address of Employer _____ City _____ State _____

Insurance Company _____ Group# _____ Policy/ID# _____

Insurance Co. Address _____ City _____ State _____

How much is your deductible? _____ How much is your co-pay? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING**

Name of Insured _____ Relation to Patient _____

Social Security# _____ Work Phone _____

Address of Employer _____ City _____ State _____

Insurance Company _____ Group# _____

Insurance Co. Address _____ City _____ State _____

How much is your deductible? _____ How much is your co-pay? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Surgical Care to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to ANDREW SAEED IRANIHA, M.D., F.A.C.S. insurance benefits otherwise payable to me. I understand with my Medical carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient (or parent of minor)

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