Philip A. Robinson, M.D.

Infectious Diseases
320 Superior Avenue, Suite #290
Newport Beach, CA 92663

Patient Information:

Last Name:_____ First:_____Middle:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Birthday:_____Social Security #:_____Driver's License #_____

Circle: Male / Female Marital Status: M / D / S / W

Referred by:

Employment Information:

Occupation:_____Employed by:_____

Address:_____City:_____State:_____Zip Code:_____

Telephone #:_____

Emergency Contact Information:

Name:_____Relationship:_____

Address:_____City:_____State:_____Zip Code:_____

Telephone #:_____ Cell Phone:_____

Insurance Information: (skip this section if providing photocopy of insurance card)
Primary Insurance Carrier:_____
Address:_____City:_____State:_____Zip Code:_____
Insured's Name:_____ Birthdate:_____Social Security #_____
Relationship to Patient:_____ Insured's Employer:_____
Insured's Group #:_____ ID #:_____Policy #:_____
Effective Dates of Policy: From:_____To:_____ Phone #:_____
Secondary Insurance Carrier:_____
Address:_____City:_____State:_____Zip Code:_____
Insured's Name:_____ Birthdate:_____Social Security #_____
Relationship to Patient:_____ Insured's Employer:_____
Insured's Group #:_____ ID #:_____Policy #:_____
Effective Dates of Policy: From:_____To:_____ Phone #:_____

ALLERGIES:

Assignment of Benefits/Financial Agreement:

I hereby give authorization for payment of insurance benefits to be made directly to Philip A. Robinson, M.D. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance company. (Medicare patients are subject to Medicare's policies and regulations.) I hereby authorize this healthcare provider to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____Date:_____