25751 McBean Parkway
Suite 215
Valencia, CA 91355
Phone (661) 253-3399
Fax (661) 253-3999

NEW PATIENT INFORMATION

Tarek Bittar, M.D.
Orthopedic Surgery & Sports Medicine

19950 Rinaldi St.
Suite 101D
Porter Ranch, Ca. 91326
Phone (818) 256-1948
Fax (661) 253-3999

Please fill out ALL sections, sign and date

PATIENT INFORMATION

Today's Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ D.O.B.: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ Zip: _____

Marital Status: M D S W Spouse's Name: _____ Social Security #: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ Family M.D.: _____

GUARANTOR / INSURED INFORMATION (Person Responsible for Payment)

Insured's Name: _____ D.O.B.: _____ Social Security #: _____

Insured's Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Insured's Work Address: _____ City: _____ Zip: _____

Primary Insurance Company: _____

Policy No.: _____ Group No.: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Co.: _____

IMPORTANT NOTES

IT IS OUR OFFICE POLICY TO COLLECT ALL DEDUCTIBLES, CO PAYS AND CO-INSURANCE AT THE TIME OF YOUR VISIT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby give authorization for payment of insurance benefits to be made to Dr. Bittar for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of denial, I agree to pay all costs of collections and reasonable attorney's fee. I authorize this healthcare provider to release all information necessary to secure the payment of benefits. I authorize any holder of medical information about me to release the information needed to determine these benefits of the benefits payable to related services. I further agree that a photocopy of this agreement shall be as valid as an original. I do hereby authorize Dr. Tarek Bittar to administer medical treatment to myself, or to any child in my absence. I also agree that the above information is true and correct.

_____ _____

Patient Signature Date