Newport Orthopedics
A Lifespan Physician Group Practice
Delivering health with care®

Orthopedics, Joint Replacement and Sports Medicine
19 Friendship Street, Suite 130
Newport, RI 02840
Phone: 401.845-1474 FAX 401.845-1477

PATIENT REGISTRATION FORM

PLEASE COMPLETE FORM IN FULL

Today's Date:	**Primary Care Provider (PCP):**

PATIENT DEMOGRAPHICS

Patient's Legal Name:	Date of Birth:
_____ , _____ _____ *Last* *First* *Middle Initial*	_____ *MM/DD/YYYY*

Address:

_____ _____ _____ _____
Street *City* *State* *Zip Code*

Social Security Number:	Sex: M F	Preferred Pharmacy: Pharmacy Address:

Home Phone #:	Work Phone #:	Mobile Phone #:
Occupation:	Employer:	Email Address:

Preferred Language: *Needs Interpreter?* Y N	Race:	Ethnicity:
Marital Status:	Aliases:	

Referred to this Clinic by (provider name):	Primary Care Provider:

EMERGENCY CONTACT

Name: _____ , _____ _____ *Last* *First* *Middle Initial*	Relationship to Patient:

Address:

_____ _____ _____ _____
Street *City* *State* *Zip Code*

Home Phone #:	Work Phone #:	Mobile Phone #:

GUARANTOR INFORMATION – Person financially responsible. Guarantor is patient if at least 18 years of age.

Guarantor Name: *Please complete if guarantor is not the patient*			**Date of Birth:**
_____ ,	_____	_____	_____
Last	*First*	*Middle Initial*	*MM/DD/YYYY*

Address:

_____ _____ _____ _____

Street *City* *State* *Zip Code*

Work Phone #:	Home Phone #:	Mobile Phone #:

Is guarantor a Lifespan patient? **Y** **N**	Guarantor's Social Security Number:

INSURANCE COVERAGE - Please provide your insurance card to scan

Name of Primary Insurance:

Subscriber's name on card:	Subscriber's SSN:	Date of Birth:	Subscriber ID #:	Group #:

Patient's relationship to subscriber: Patient's Insurance ID#

Name of Secondary Insurance (if applicable):

Subscriber's name on card:	Subscriber's SSN:	Date of Birth:	Subscriber ID #:	Group #:

Patient's relationship to subscriber: Patient's Insurance ID#

FINANCIAL STATEMENT: All professional services rendered are charged to the patient unless you have Federal Medicare or State Medical Assistance. The patient is financially responsible for all fees incurred. Necessary forms for all private insurance will be completed to expedite insurance company payments directly to the patient. Payment is expected at the time of service. It is the patient's responsibility to understand which treatment options are covered by his/her health care policy.

Insurance Authorization and Assignment

I hereby authorize members of LPG NHCC Medical Associates to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for services rendered to myself of my dependents. I understand I am responsible for any amount not covered by insurance.

Patient/Guardian signature **Date**

AUTHORIZATION FOR TREATMENT: I hereby authorize the members of LPG-NHCC Medical Associates to perform any treatment and/or procedure which in their judgment may be necessary or advisable for my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of my treatment. I have been afforded the opportunity to ask questions and they have been answered to my satisfaction. The risks, benefits and alternative, including the alternative of no treatment at all have been discussed.

Patient/Guardian signature **Date**

PRESCRIPTION HISTORY CONSENT: I authorize the providers of LPG-NHCC Medical Associates to review any prescription history available from the insurance carrier or pharmacy through my electronic health record.

Patient/Guardian signature **Date**