Coastal Healthcare REGISTRATION ADULT

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION ***PRINT*** ***REFERRED BY: ___________________________***

Last: _______________________________________

First____________________________ MI______

Previous Name:______________________________

Address_____________________________________

City____

State_____________________ Zip____________

Please put an (X) next to your preferred contact number:

Home#_____________________________(__)

Cell #_____________________________(___)

Work #_____________________Ext ______(___)

PRIMARY CARE DR:______________________

Date of Birth__________________ AGE ________

Sex: ____Male ____Female

Marital Status: ___Divorced ___Single ___Partner

___Married ___Widowed ___Legally Separated

Social Security #_________________________

Employer:_______________________________

Employ status: __F/T __P/T __Self-Employ

__Retired __Not Employed __Military

Student: ___F/T ___P/T

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INS CO _______________________________	INS CO. ______________________________
ID #_________________________ COPAY $ _______	ID #_________________________ COPAY $ _______
PT's Relationship: ___Self __Spouse __Child __Partner	PT's Relation: __Self __Spouse __Child __Partner

If Insured is other than patient (self):

Insured name: ___________________________	Insured name: ___________________________
SS#______________________ DOB____________	SS#______________________DOB____________
Employer:_______________________________	Employer:_______________________________

EMERGENCY CONTACT:

Name:____ Relationship_______________________________

Address if different than patient: Phone:___________________________________

Street:____ City________________________ Zip____________

LIVING WILL (Advanced Medical Directive) Do you have one? _____ NO _____ YES

If Yes, please provide a copy for your medical records with your doctor.

Private Insurance Authorization Assignment of Benefits/ Informaton Release:
I, the undersigned, authorize payment of a medical benefit to Coastal Healthcare for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

SIGNATURE:_______________________________________ DATE:__________________

Medicare Lifetime Signature of File:

I request that payment of authorized Medicare benefits be made on my behalf to Coastal Healthcare for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents and Medigap insurers, any information needed to determine these benefits or any other benefits payable for related services.

SIGNATURE:_______________________________________ DATE:__________________