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 _____(___)

email:

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:_____