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 the your preferred contact number:

Home#_____(__)

Cell #_____(___)

Work #_____Ext _____(___)

PRIMARY CARE DR:_____

Date of Birth_____

Sex: ____Male ____Female

Marital Status: __Divorced __Single ___Partner

___Married __Widowed __Legally Spearated

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 #_____	ID #_____
PT's Relationship: ___Self __Spouse __Child __Part	Pt's Relatiion: __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:_____

COASTAL HEALTHCARE PATIENT ADDITIONAL INFO

Patient Name: _____ Patient/Guardian Email: _____

OK to use email and/or text for appointment confirmation?

EMAIL ____Yes ___NO TEXT ____ Yes ____NO

BRIEF ____ EXTENDED ____

Race: (Check one below)	
_____ American Indian or Native Alaskan _____ Asian _____ Native Hawaiian or Other Pacific Islander _____ Black or African American _____ White _____ Hispanic _____ Other Race _____ Other Pacific Islander _____ Unreported or refused to report	**Ethnicity: (Check one below)** _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Refused to Report

Language other than English: _____

PATIENT EMPLOYMENT INFORMATION

Employer address:_____ City_____ Zip_____

Employer Phone number:_____

OK to leave message at work? _____ Yes ____No

PHARMACY INFORMATION

Please list your preferred Local and Mail Order Pharmacy. Prescriptions will be done electronicaly directly to your requested pharmacy. Some class drugs may require a written script.

LOCAL PHARMACY:

Name:_____

Address:_____

City:_____Zip_____

Phone #_____

Fax: _____

MAIL ORDER PHARMACY:

Name:_____

Address:_____

City:_____Zip_____

Phone #_____

Fax: _____

Rx History Consent:

I hereby give you permission to view my prescription information and history from all external sources. By signing this consent form, you are agreeing that COASTAL HEALTHCARE can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for all treatment purposes.

Patient Signature _____ Date _____