COASTAL CAROLINA FAMILY PRACTICE
PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient # _____

Patient Name _____ Social Security # _____ ☐ Male ☐ Female

Birthdate _____ Home Phone _____ Cell Phone _____ Race _____

Address _____ City _____ State _____ Zip _____

Email Address: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent's employer _____ Work Phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college_____ City _____ State _____

Language Preference _____ Disability: Hearing ☐ Visual ☐ Literacy ☐

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's license # _____ Birthdate _____

Employer _____ Work Phone _____

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information – Must Present Insurance Cards

PLEASE LIST COVERAGE IN THE CORRECT ORDER IT IS TO BE FILED

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

PATIENT INFORMATION

COASTAL CAROLINA FAMILY PRACTICE

CONSENTS/AUTHORIZATIONS

AUTHORIZATION TO TREAT: I hereby authorize COASTAL CAROLINA FAMILY PRACTICE to provide treatment as prescribed by my physician. I understand that I am financially responsible for the charges incurred as a result of treatment that are not paid by my insurance/third-party payers.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize COASTAL CAROLINA FAMILY PRACTICE to release any information, including the diagnosis and records, of any treatment or examination rendered to me or my child to any insurance/third-party payers.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to COASTAL CAROLINA FAMILY PRACTICE for benefits, if any, otherwise payable to me by insurance/third-party payers.

MISSED APPOINTMENT CHARGE: Our time is valuable just as is your time, therefore, there may be a $25.00 charge for each appointment not kept. There will be no charge if you call and cancel your appointment 24 hours in advance. The charge is the sole responsibility of the patient. The insurance company will NOT pay for this. If four (4) appointments are missed without notification, your remaining scheduled appointments will be cancelled and your doctor notified.

Patient/Guarantor Signature: _____ Date: _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, or administrative operations, related to my treatment and payment. I understand that the identity of designated parties must be verified before the release of information, and the designee must be 18 years of age or older.

AUTHORIZED DESIGNEES:

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

_____

Patient Name

_____

Patient Signature

_____

Date