PATIENT INFORMATION
(Please Print and Complete Entire Form)

COASTAL SURGERY SPECIALISTS

PATIENT INFORMATION

LAST NAME *	FIRST NAME *	MIDDLE *	PREFERRED	DATE OF BIRTH *
☐ MALE * ☐ FEMALE	SOCIAL SECURITY NUMBER *	RACE	☐ MARRIED ☐ DIVORCED ☐ SINGLE * ☐ WIDOWED ☐ SEPARATED	DRIVERS LICENSE NUMBER
ADDRESS *	CITY *	STATE *	ZIP CODE *	E-MAIL ADDRESS
HOME PHONE *	WORK PHONE *	MOBILE PHONE	PRIMARY PHONE *	
SPOUSE OR GUARDIAN NAME *	SPOUSE OR GUARDIAN SOCIAL SEC. NUMBER *	SPOUSE OR GUARDIAN DATE OF BIRTH *		
PHARMACY NAME AND ADDRESS*				

EMPLOYMENT INFORMATION

PATIENT EMPLOYED BY:	POSTION OR DEPARTMENT	WORK PHONE	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SPOUSE EMPLOYED BY:	SPOUSE'S EMPLOYER ADDRESS		

INSURANCE INFORMATION

IF YOU ARE NOT SURE ABOUT PRIMARY INSURANCE, PLEASE CALL INSURANCE COMPANY TO VERIFY. PLEASE FURNISH COPY OF CARD(S).

PRIMARY INSURANCE CO. NAME *	NAME OF POLICYHOLDER *	POLICY NUMBER	GROUP NUMBER
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S SOCIAL SECURITY NUMBER	POLICYHOLDER'S RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE CO. NAME *	NAME OF POLICYHOLDER *	POLICY NUMBER	GROUP NUMBER
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S SOCIAL SECURITY NUMBER	POLICYHOLDER'S RELATIONSHIP TO PATIENT	

MINORS ONLY - RESPONSIBLE PARTY INFORMATION

NOTE: PARENT BRINGING CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF ACCOUNT.
IF 18 OR OVER, YOU ARE RESPONSIBLE FOR INCURRED CHARGES. IF STUDENT, PARENT SIGNATURE REQUIRED

PERSON RESPONSIBLE FOR MEDICAL EXPENSES *	RELATIONSHIP TO PATIENT *	HOME PHONE	
ADDRESS	CITY	STATE	ZIP CODE
EMPLOYED BY	WORK PHONE	SOCIAL SEC. NO.	

EMERGENCY INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP	
ADDRESS	CITY	STATE / ZIP CODE
PHONE NUMBER	WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	

CONSENT FOR TREATMENT – AUTHORIZATION OF BENEFITS – RELEASE OF MEDICAL RECORDS

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize Coastal Surgery Specialists to furnish the protected health information to Center for Medicare & Medicaid Services or any other insurance carriers as described in the Notice of Privacy Practices, and I hereby assign to the physician all payments for medical services rendered to myself or dependent. In addition, I authorize release of my medical records to other health care providers as appropriate for coordination and management of my treatment. I understand this authorization will remain in effect for as long as my dependent or I remain a patient:

(**Signature**) Patient or Guardian ____ Date: ____________________