Coastal Orthopedics and Sports Medicine

Patient Information – In order to better serve you we need the following information.

Today's Date: ______________________
Patient Name: ______________________ **Birth date:** _________________**Age:** ___________
SSN: _______________________ ☐**Male** ☐**Female** **Home Phone:** _____________________
Address 1: ____
Address 2: ____
City: ________________________ **State:** ________________ **Zip:** ______________________
Check the box(s) that apply: ☐**Minor** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widow** ☐**Separated**

Patients or Parents Home Phone: _____________ **Work:** ____________ **Cell:** ____________
Business Address: ____
City: ________________________ **State:** ________________ **Zip:**______________________
Spouse or Parents Name: ____
Employer: ___________________________________ **Work Phone:** ____________________
Emergency Contact: _______________________________ **Phone:** ____________________
Family Physician or Primary Doctor: ____
Person Consulting/Referring you to us: ____

Responsible Party:
Person responsible for this account: _______________ **Relationship to patient:** __________
Address (if different from above)**:** ______________________ **Phone:** ____________________
Drivers License: ______________________________ **Birth date:** ______________________
Employer: ___________________________________ **Work Phone:** ____________________

Insurance Information:
Name of Insured: ______________________________ **Relationship to patient:** ___________
SS# of the insured: _____________________________ **Birth date:** ______________________
Employer Info (if different from above)**:** **Name of Employer:** _________________________
Address: ____ **Phone:** ____________________
Name of Insurance Company: ____
Address: ____
Your Deductible Amount: _____ **How much have you used:** _____ **Copay Amount:** ______

Do you have additional Insurance? ☐**Yes** ☐**No** If yes, complete the following section.

Name of Insured: ______________________________ **Relationship to patient:** ____________
SS# of the insured: _____________________________ **Birth date:** ______________________
Employer Info (if different from above)**:** **Name of Employer:** _________________________
Address: ____ **Phone:** ____________________
Name of Insurance Company: ____
Address: ____
Your Deductible Amount: _____ **How much have you used:** _____ **Copay Amount:** ______

I authorize the release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for the total amount charged for all services rendered.

X____ **Date:** _________________________
Signature of patient, or parent or guardian if minor