COASTAL ORTHOPEDICS & SPORTS MEDICINE, P.A.

PATIENT REGISTRATION and AUTHORIZATION

Please Print **Referred by:**

Name _____ Sex____ Age____ Birthdate _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address _____ Soc. Sec. # _____

City _____ State_____ Zip_____ Employer /Occupation_____

Home Phone _____ Address_____

Work Phone _____ City _____ State_____ Zip_____

IS THIS A WORKMAN'S COMP INJURY?

BILLING: Please complete if person responsible for this bill is other than above patient:

Name_____ Relationship to Patient _____ Soc. Sec.#_____

Address_____ Birthdate_____ Dept. # Badge#_____

City_____State_____ Zip_____ Employer _____Occupation_____

Home Phone _____ Address_____

Work Phone _____ City_____ State_____Zip_____

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one insurance, supply information of both insurances. Please list all numbers on your card(s). Please check your insurance policy for waiting period before coverage or pre-existing clauses. **IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION, or PRE-ADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.**

Primary Insurance Name_____	Secondary Insurance Name_____
Address_____	Address_____
Insured (name on ID card)_____	Insured (name on ID card)_____
Relationship to Patient	Relationship to Patient
☐ self ☐ spouse ☐ child ☐ other	☐ self ☐ spouse ☐ child ☐ other
Insured ID No._____	Insured ID No._____
Group No._____	Group No._____
Company Name_____	Company Name_____
Effective Date_____	Effective Date_____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Coastal Orthopedics to furnish information to insurance carriers concerning my treatment and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. For worker's compensation claims, I further authorize Coastal Orthopedics to release information regarding my examination or treatment to my employer or their insurance carrier.

Date_____ Signature_____

Please state your problem. Date of injury?

School _____

Grade _____

Type of injury

- ☐ Workman's Comp
- ☐ Motorvehicle accident
- ☐ Other

Is litigation pending?

Have you had previous treatment? Please list physician and treatment

MEDICAL INFORMATION

Current medications: Allergies:

- ☐ Asthma
- ☐ Diabetes
- ☐ Stomach
- ☐ Bleeding problems
- ☐ Are you pregnant?

Other pertinent medical information (medical illnesses, accidents, surgeries, etc.)

I would/would not like a copy of the notes from this visit to be sent to my family doctor, Dr. _____

Signature _____