



# COASTAL HEALTH CENTER

## Patient Information Form

Please Print

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ SS# \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Parent's Name \_\_\_\_\_ Work # \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_  
 Email Address \_\_\_\_\_

Date of Injury (Worker's Compensation) \_\_\_\_\_  
 Employer \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

### Authorization to Disclose Information

To \_\_\_\_\_  
 Telephone \_\_\_\_\_ Relationship \_\_\_\_\_

### Health Insurance Information

Person Responsible for bills \_\_\_\_\_  
 Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_  
 Blue Cross/Blue Shield Cert.# \_\_\_\_\_ Group # \_\_\_\_\_  
 Other Insurance \_\_\_\_\_  
 Address \_\_\_\_\_  
 Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Telephone \_\_\_\_\_

I assign all medical and/or surgical benefits to which I am entitled to Stephen H. Nightingale, MD d/b/a Coastal Health Center. I authorize any holder of medical information about me to be released to Medicare and MediGap or my insurance and its agents any information needed to determine these benefits or the benefits payable for related services. This is to include any private insurance that may be responsible for my health care. A photocopy of this assignment is to be considered as valid as an original; I understand that I am responsible at any time of service for any charges not covered by my own insurance for services rendered. I also hereby authorize that my medical record may be copied and forwarded to either my family physician or any other physician used in medical consultation.

Please contact our office 24 hours in advance for cancellation of appointments. If you fail to show for an appointment or do not call, a no-show charge may be applied to your account. Three accumulated no-show appointments in one year may result in discharge from the practice. The fees are \$10.00 for a missed office visit, \$10.00 for a missed follow-up exam, and \$25.00 for a missed physical examination.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are under 18 years of age, must be signed by either a parent or guardian. 5-03