PATIENT INFORMATION RECORD

Coastal Carolina Health Care, PA

(FOR OFFICE USE ONLY)

0 WORKMAN'S COMPENSATION

0 NEW PATIENT

0 UPDATE

MEDICAL RECORD NO:_____

DOCTOR'S NAME:_____

PLEASE PRINT ALL INFORMATION

NAME:_____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

BIRTH DATE:_____ SEX: F M WHICH PROVIDER ARE YOU GOING TO SEE?_____

SSN:_____ DRIVER'S LICENSE # AND STATE:_____

MAILING ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PLEASE INDICATE BELOW YOUR PRIMARY CONTACT NUMBERS: IF YOUR PRIMARY CONTACT IS A CELLPHONE, YOU ARE GIVING CCHC CONSENT TO CONTACT YOU AND SEND APPOINTMENT AND OTHER HEALTH RELATED REMINDERS TO YOUR CELL PHONE

Primary Contact #: _____ (Circle phone # type) Home Mobile/Cell Work

Secondary Contact #: _____ (Circle phone # type) Home Mobile/Cell Work

PATIENT EMAIL ADDRESS:_____EMPLOYER:_____

SPOUSE:_____SPOUSE'S EMPLOYER:_____PHONE #:_____

NAME OF EMERGENCY CONTACT:_____PHONE #:_____RELATIONSHIP:_____

HOW DID YOU HEAR ABOUT US? FRIEND NEIGHBOR URGENT CARE OTHER:_____

FOR MINORS UNDER 18: MOTHER'S NAME:_____DATE OF BIRTH:_____

EMPLOYER:_____WORK #:_____

FATHER'S NAME:_____DATE OF BIRTH:_____

EMPLOYER: _____WORK #:_____

DO YOU WANT COASTAL CAROLINA HEALTH CARE, P.A. TO FILE YOUR INSURANCE? YES NO
(Our office must file your insurance if you have Medicare) If YES, please complete the following. **Please note: If you do not give us your correct and complete insurance information at the time of your visit, our office cannot file your insurance for this visit.**

PRIMARY INSURANCE CO Name: _____Member ID #_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

POLICY HOLDER'S SS#:_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER:_____

SECONDARY INSURANCE CO Name: _____Member ID #_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

POLICY HOLDER'S SS#:_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER:_____

TERTIARY INSURANCE CO Name: _____Member ID #_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

POLICY HOLDER'S SS#:_____

PATIENT'S RELATIONSHIP TO POLICY HOLDER:_____

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing care quality and reviewing competence of health care professionals.

I consent to the use of disclosure of my protected information by all divisions of Coastal Carolina Heath Care, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coastal Carolina Health Care, P.A. including the use of outside medical record auditing consultants to review my protected health care information to conduct medical record audits. I understand that the diagnosis or treatment of me by Coastal Carolina Health Care, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

PLEASE SIGN BELOW:

I hereby authorize Coastal Carolina Health Care, P.A. to administer any treatment as deemed necessary or advisable in the diagnosis and treatment of this patient. This authorization expires in five years.

Signature:_____ **Date:**_____

All Professional Services rendered 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 in advance with our office personnel. I realize your office files my insurance as a courtesy to me and that I am ultimately responsible for payment of my bill and follow-up with my insurance company if they do not pay promptly.
I request that payment of authorized benefits be made, on my behalf, to Coastal Carolina Health Care, P.A., for any services furnished to me by that association. I hereby authorize any holder of medical information about me to furnish information to insurance carriers, including The Centers for Medicare and Medicaid Services (CMS) and its agents concerning my illness and treatments to determine benefits or the benefits payable for related services. I understand that I am responsible for any amount not covered by insurance. This authorization expires in five years.

Signature:_____ **Date:**_____

I consent to the use of disclosure of my protected information by all divisions of Coastal Carolina Heath Care, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coastal Carolina Health Care, P.A. including the use of outside medical record auditing consultants to review my protected health care information to conduct medical record audits. I understand that the diagnosis or treatment of me by Coastal Carolina Health Care, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

Signature:_____ **Date:**_____