version 3/2016

WELCOME TO COASTAL PODIATRY, INC.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.

ADDRESS	CITY	STATE	ZIP CODE

SEX	MARITAL STATUS	DATE OF BIRTH	CONSENT TO TEXT MESSAGES?	PERFERRED NO:
❑ M ❑ F	❑ S ❑ M ❑ D ❑ W	/ /	❑ YES ❑ NO	( )

HOME PHONE	WORK PHONE	CELL PHONE	PREFERED CONTACT PHONE
( )	( )	( )	❑ HOME ❑ WORK ❑ CELL

RACE			ETHNICITY	
	❑ WHITE	❑ ASIAN	❑ OTHER RACE	❑ HISPANIC OR LATINO
	❑ BLACK OR AFRICAN AMERICAN	❑ MORE THAN ONE RACE		❑ NOT HISPANIC OR LATINO
	❑ AMERICAN INDIAN OR ALASKA NATIVE	❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER		

EMAIL ADDRESS	PRIMARY CARE PHYSICIAN	OCCUPATION

RESPONSIBLE PARTY

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE	RELATIONSHIP TO PATIENT
( )	( )	( )	

EMERGENCY

EMERGENCY CONTACT	RELATIONSHIP	PREFERRED NO.
		( )

ADDRESS	CITY	STATE	ZIP CODE

PHARMACY

PHARMACY NAME	PHONE NO	FAX NO
	( )	( )

ADDRESS	CITY	STATE	ZIP CODE

INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE	SELF PAY ❑ YES ❑ NO
		WORKMAN'S COMP ❑ YES ❑ NO

WORKMAN'S COMP POLICY NAME	POLICY NO	POLICY PHONE NO
		( )

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I have authorized treatment by any Coastal Podiatry, Inc. provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines as noncovered services, as well as, attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE

MEDICARE PATIENTS ONLY

IF YOU HAVE MEDICARE OR MEDICARE COMMERCIAL PLAN - PLEASE COMPLETE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Podiatry, Inc. for any services furnished me by their physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determinatin of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE	DATE