

COASTAL COSMETIC CENTER, PA/COASTAL SURGERY CENTER, LLC
REGISTRATION FORM
(Please Print)

Today's date:

PCP:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home Phone: ()		
					Cell Phone: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Work phone : ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Patient's E-Mail Address:					May we contact you through e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		

INSURANCE INFORMATION

(Please give your insurance card(s) & drivers license to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()		
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance				<input type="checkbox"/> HMO	<input type="checkbox"/> PPO		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Cosmetic, PA/Coastal Surgery Center, LLC or insurance company to release any information required to process my claims.

Insurance co-payments are due at the time of service. Giving fraudulent insurance information could be considered theft of services. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate.

Patient/Guardian signature

Date