

**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?		If not, what is your legal name?			(Former name):			Birth date:		Age:	Sex:
<input type="checkbox"/> Yes	<input type="checkbox"/> No							/ /			<input type="checkbox"/> M <input type="checkbox"/> F
Street address:					Social Security no.:			Home phone : () -			
								Cell No: () -			
P.O. box:			City:			State:		ZIP Code:			
Occupation:			Employer:				Employer phone no.:				
							()				
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					
Other family members seen here:											
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.:			
Birth date:											
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.:		
							()		()		
<p>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.</p> <p>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.</p>											
Email Address:							<input type="checkbox"/> Yes	May we contact you through email		<input type="checkbox"/> No	
Patient/Guardian signature								Date			

MEDICAL HISTORY FORM

Coastal Cosmetic Center

4147 Southpoint Drive East • Jacksonville, FL 32216

Name: _____ Date: _____

Age: ____ Date of Birth: _____ Sex: M F Married: Y N Occupation: _____

SPECIFIC REASON FOR SEEING PHYSICIAN: _____

HABITS:

Smoke: Y N Amount: _____ Coffee/Tea/Cola: Y N Amount: _____
Alcohol: Y N Amount: _____ Daily Exercise: Y N Amount: _____

MEDICATIONS: List dosage or number of pills per day

Prescription Drugs	Non-Prescription (Vitamins; Herbs)
_____	_____
_____	_____
_____	_____

Regular Aspirin Use: Y N Dosage & Frequency: _____

NSAID (Advil, Motrin, and Ibuprofen): Y N Dosage & Frequency: _____

Cortisone Injections Past Year: Y N Date(s) and injection location: _____

Allergies- Food or Drug: Y N List them and type of reaction: _____

Latex Allergy: Y N Tape Allergy: Y N

FAMILY HISTORY:

Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y N	Coronary Surgery: Y N	Kidney Disease: Y N
Abnormal Clotting: Y N	Diabetes: Y N	Tuberculosis: Y N
Anesthetic Problems: Y N	Heart Attack: Y N	Other Serious Illness: Y N
Cancer: Y N	Hypertension: Y N	Breast Cancer: Y N

Please describe questions with a "Yes" answer: _____

PERSONAL HISTORY: Do you currently have or ever had:

Abnormal Bleeding: Y N	Asthma: Y N	Hypertension: Y N
Abnormal Clotting: Y N	Diabetes: Y N	Mitral Valve Prolapse: Y N
Acid Regurgitation: Y N	Fainting Spell: Y N	Sleep Apnea: Y N
Anemia: Y N	Heart Attack: Y N	Snoring: Y N
Angina: Y N	Hepatitis: Y N	Other Serious Illness: Y N

Please describe questions with a "Yes" answer: _____

Have you ever received a blood transfusion? Y N If yes, what year?
Have you been tested for HIV? Y N If yes, what year? Test results: Positive Negative
Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N Dentures: Y N
Previous surgeries, year and type of procedures: _____

Indicate the type(s) of anesthesia received in the past, list any complications/reactions you experienced.

Local anesthesia – complications/reactions: _____
General anesthesia - complications/reactions: _____
Spinal/Epidural – complications/reactions: _____

Date last seen by Primary Care Physician: _____
Primary Care Physician (name) _____ (telephone) (____) _____
(Address) _____

Physician Signature

Date

COASTAL COSMETIC CENTER, PA/ COASTAL SURGERY CENTER, LLC

Southpoint Office

4147 Southpoint Drive East
Jacksonville, FL 32216
Phone: (904) 332-6774 Fax: (904) 3329137

Fleming Island Office

1689 Eagle Harbor Pkwy Ste-B
Jacksonville, FL 32003
Phone: (904) 332-6774 Fax: (904) 3329137

AUTHORIZATION TO RELEASE INFORMATION

TO FAMILY/ FRIENDS (PLEASE BE SPECIFIC)

I, _____ authorize my information to be given to:
(Patient Name)

Name: _____

Phone : _____

Please check here if you wish to make emergency contact.

Name: _____

Phone : _____

Please check here if you wish to make emergency contact.

Name: _____

Phone : _____

Please check here if you wish to make emergency contact.

Regarding the **initialed** items below; I understand that by signing this form **only** the person(s) designated above are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **All Information** I understand that the person(s) listed above will have availability to all of my medical and personal information that the office of Coastal Cosmetic Center, PA / Coastal Surgery Center, LLC has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and / or change this authorization.

- _____ APPOINTMENT DATES/ TIMES
- _____ TEST RESULTS
- _____ OFFICE NOTES
- _____ SURGERY INFORMATION
- _____ INSURANCE INFORMATION
- _____ ALL INFORMATION
- _____ OTHER _____

X _____
Patient Signature

Date

X _____
Witness Signature

Date

Leonard J. Spillert, MD

Timothy E. Fee, MD

William A. Wallace, MD

Coastal Cosmetic Center, P.A.
4147 Southpoint Drive, East
Jacksonville, Florida 32216

AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, Leonard J. Spillert, M.D., Timothy E. Fee, M.D. and/ or William A. Wallace, M.D. are often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously. We now ask that you do so as well.

AUTHORIZATION FOR BEFORE & AFTER PHOTO

I hereby authorize Dr. Leonard J. Spillert, Dr. Timothy E. Fee and/ or Dr. Clinton B. Webster to use my preoperative and postoperative photos in their before and after presentation to other patients interested in the same procedures. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that this consent has no bearing on medical care. This release will remain in effect for 7 years unless revoked in writing or Coastal Cosmetic Center, Dr. Spillert, Dr. Fee, and/ or Dr. Webster has taken action in reliance to this consent.

_____		Patient Refused:	_____	
Signature	Date		Signature	Date
_____			_____	
Print			Print	

AUTHORIZATION FOR WEBSITE

I hereby authorize Dr. Leonard J. Spillert, Dr. Timothy E. Fee and/ or Dr. Clinton B. Webster to use my photos for website presentations. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all presentations. I understand that this consent has no bearing on my medical care. This release will remain in effect for 7 years unless revoked in writing or Coastal Cosmetic Center, Dr. Spillert, Dr. Fee and/ or Dr. Webster has taken action in reliance to this consent.

_____		Patient Refused:	_____	
Signature	Date		Signature	Date
_____			_____	
Print			Print	

Coastal Cosmetic Center, PA
4147 Southpoint Drive East
Jacksonville, FL. 32216

Person Financially Responsible

Name; _____ Birthdate; _____ / _____ / _____

SS# _____ Drivers License # _____ State _____

Daytime Phone _____ Evening Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Employers Address _____ City _____ State _____ Zip _____

Employers Phone _____

PAYMENT AT TIME OF SERVICE

It is our **office policy** that payments are due **at time of service**. If we have a contract with your insurance company we will file your insurance. **However, you are responsible for all copays, deductibles, and non-covered services at the time of service.**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in this information.

Signature; _____ Relationship to Patient; _____ Today's Date; _____

ASSIGNMENT AND RELEASE

I hereby authorize the attending physician and consulting physicians (such as Radiologist, Anesthesiologist, Pathologist, etc.) to bill my insurance company directly and assign all benefits to the physicians for their services. I understand that I am financially responsible to these physicians for charges not paid by my insurance company in a reasonable time. A photostatic copy or reproduction of this authorization will be as valid as the original.

Signature; _____ Relationship to Patient; _____ Today's Date; _____

**Acknowledgment of Receipt of Privacy Notice for
Coastal Cosmetic Center, PA / Coastal Surgery Center, LLC**

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our notice.

Print Name of Patient or Legal Representative

Signature of Patient or Legal Representative

Date

Signature of Employee

Front Office

Title of Employee

Date