# COASTAL PRIMARY CARE
## James Joachim, M.D.

# PATIENT REGISTRATION

**NAME:**
**Last:______________________________First:_________________________MI______Suffix_____Marital Status____________**

**STREET:**
**Address___________________________________________City______________________________ST______ Zip____________**

**MAILING:**
**Address: __________________________________City______________________________ ST_______ Zip________________**

**Home Phone:________________ Cell Phone___________________ Birth date _______ ________ Age:__________________**

**Social Security #:_______-_____-______ Sex: { } M { } F Referred by: __________________________________________**

**Employer: __________________________________ Occupation: _______________________ Work Phone: _______________**

**Drivers License #:__________________________ Spouse's Name: ______________________ Phone #___________________**

**<u>IF UNDER 18:</u> School: ___________________________________ Responsible Party: __________________________________**

**Relationship___________________________**

**EMERGENCY CONTACT: _____________________________________ Relationship to patient: ________________________**

**Address: ____________________________________________________________ Phone #:_______________________________**

**ASSIGNMENT OF BENEFITS:**

**I hereby authorize direct payment of benefits to Coastal Primary Care for services rendered to me. I understand that I am financially responsible for any balance not covered by my insurance. I understand that there will be a fee incurred for missed appointments and appointments not cancelled 24 hours in advance: $75.00 for a Physical appointment or $25.00 for regular office visits. I understand that I am responsible for any copayment, deductible, or coinsurance at the time of my appointment and will have to reschedule appointment if unable to pay. I understand that if I am a self-pay patient (without insurance), I will be required to pay prior to being seen.**
**I also understand that any outstanding balance that results from any unpaid co-pays, coinsurance or deductible will be subject to a 1.5% finance charge.**

**Patient/Guardian Signature: ______________________________________________________________**

**Date: ___________________________**