New Patient Registration Form

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name (If Applicable)		
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the physician you are seeing today?

☐ Referral Line ☐ Community Event Referral ☐ Direct Mail ☐ ER ☐ Established Patient
☐ Family/Friend ☐ Hospital ☐ Insurance ☐ Internet/Website ☐ Location/Drive By ☐ Newspaper
☐ Unknown ☐ Physician Referral ☐ Radio/TV ☐ Yellow Pages

Responsible Party

Complete this section only if the patient is a minor

Responsible Party Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City	State / Zip	City	State / Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City	State / Zip	City	State / Zip

Signature of Patient, Parent, or Legal Guardian _____ Date _____

COASTAL FAMILY PRACTICE & ACUTE CARE CENTER, LLC

Notice of Privacy Practices

I understand and have been provided (available upon request) with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon

Financial Responsibility

I hereby authorize payment of medical benefits directly to Coastal Family Practice and Acute Care Center, LLC and/or the attending healthcare practitioner for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding any reportable communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") , Human Immunodeficiency Virus ("HIV") , Mental Health and Substance Abuse. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Coastal Family Practice and Acute Care Center, LLC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Coastal Family Practice and Acute Care Center, LLC.

Authorization for Treatment

I authorize Coastal Family Practice and Acute Care Center, LLC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Coastal Family Practice Patient Consent Form

Patient Name: _____ Date of Birth: _____

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others listed below:

Name	Relationship	Contact Number

Consent to E-Mail for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via e-mail to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

_____ (Patient initials) I consent to emails to receive communication as stated above. I understand that this request to receive e-mails will apply to all future appointment reminds/feedback/health information unless I request a change in writing (see revocation section below).

The e-mail that I authorize to receive e-mail message for appointment reminds and general health reminders/feedback/information is _____.

REVOCATION:

I hereby revoke my request to receive any future appointment reminders, feedback, and general health via e-mail.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made with less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW**. Patients who No-Show two (2) times in a 12 month period, may be dismissed from the practice and will be denied any future appointments. Patients may also be subject to **a $25.00 fee for a No Show.**

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.
Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (850-231-9286 ext 5).

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative **Date**

Patient History

Date: _____

Name:	Female ____	Birth Date	Age
Reason for visit:	Male ____		

Health history: (Please circle "Y" if you have or have ever had any of the following)

High/Low Blood Pressure	Y	N	Gallbladder Disease	Y	N	Blood in Stool	Y	N
Heart Failure	Y	N	Persistent Hoarseness	Y	N	Kidney Stones	Y	N
Coronary Artery Disease	Y	N	Difficulty Swallowing	Y	N	Problems with Vision	Y	N
Chest Pain/Heart Attack	Y	N	Cancer	Y	N	Glaucoma	Y	N
Palpitations	Y	N	Night Sweats	Y	N	Fatigue	Y	N
Epilepsy	Y	N	Rashes	Y	N	Anxiety/Depression	Y	N
Meningitis	Y	N	Shortness of Breath	Y	N	Syphilis/Gonorrhea	Y	N
Rheumatic Fever	Y	N	Back Problems	Y	N	Chlamydia/Herpes	Y	N
Diabetes	Y	N	Swelling of Feet/Edema	Y	N	Ovarian Cyst	Y	N
Low/High Blood Sugar	Y	N	Thyroid Disease	Y	N	Fibrocystic Breast	Y	N
Chronic/Frequent Cough	Y	N	Varicose Veins	Y	N	Pelvic Inflammatory Disease	Y	N
Heartburn/Reflux	Y	N	Stomach Pain	Y	N	Endometriosis	Y	N
High Cholesterol	Y	N	Hernia	Y	N	Peripheral Vascular Disease	Y	N
Pneumonia	Y	N	Headaches/Migraine	Y	N		Y	N
Autoimmune Disease	Y	N	Arthritis	Y	N		Y	N
Eczema/Psoriasis	Y	N	Coughing up Blood	Y	N		Y	N
Gout	Y	N	Tuberculosis	Y	N		Y	N
Ulcers	Y	N	Abnormal Bowel Movements	Y	N			

Other Problems: _____

Menstrual: ___Regular ___Irregular ___Cramping ___Normal ___

Hysterectomy: Y N Number of Pregnancies _____ Number of Children _____

Weight today: _____ Weight 1 year ago: _____ Height _____ ft ____ in

Please list all medication that you are now taking, strength (in milligrams), and frequency. Include non-prescription medications, vitamins, and herbal supplements

Are you allergic to any medications? Y N If yes, please list them AND the reaction they cause

Are you under the care of any other doctor for any medical problems: Y N
If so, whom and for what medical problems:

_____

Year of Last: Tetanus Shot _____ Flu Shot _____ Pneumonia Vaccine _____ Shingles Shot _____

Date of first day of last menstrual period: ___/___/___ Contraception type _____

Number of: Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Date of last: PAP _____(Abnormal?) _____ Mammogram _____(Abnormal?) _____

Osteoporosis scan _____

Flushing/Menopausal Symptoms Y N Have you been a victim of abuse? Y N

Date of last: Prostate Exam _____ PSA (Prostate Blood Test) _____

Procedures (list year)

Chest X-Ray	Colonoscopy	Stress Test
EKG	Cholesterol (normal Y/N)	Sugar (normal Y/N)
Anteriogram	Endoscopy	

Personal habits: Smoking: Packs/day ___ How many years? ___ Alcohol: Amount/day ___ How many years ____

Exercise Y N Diet Y N Marital Status _____ # of Children ____

Caffeine: Amount/Day _____

Medical/Surgical: (Please list any hospitalizations, injuries, surgeries, serious and/or unusual illnesses)

Year		Year	
Year		Year	
Year		Year	

Family History: (Please circle Y or N if any blood relative has or has ever had any of the following)
Please indicate relative with M (mother) F (father) S (sibling) GP (grandparent)

Thyroid	Y	N		Prostate Cancer	Y	N		Hypertension	Y	N		Cholesterol	Y	N	
Mental illness	Y	N		Colon Cancer	Y	N		Heart Attack	Y	N		Asthma	Y	N	
Kidney Disease	Y	N		Lung Cancer	Y	N		Glaucoma	Y	N		Gout	Y	N	
Stroke	Y	N		Breast Cancer	Y	N		Allergy	Y	N		Epilepsy	Y	N	
Arthritis	Y	N		Ovarian Cancer	Y	N		COPD	Y	N		Tuberculosis	Y	N	
Diabetes	Y	N		Other Cancers	Y	N		Migraine	Y	N		Alzheimer's	Y	N	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____ _____ _____

Patient Signature Date Provider Signature Date