Patient Registration (Please Print Clearly)

SouthCoastHEALTH

Last Name _____ First Name _____ MI____

SSN _____ Sex_____ Date of Birth____ /____/____ Marital Status_____

Address_____ Apt. _____

City_____ State _____ Zip _____

Home #_____ Work #_____ Cell #_____

Email_____ Primary Care Physician _____

Employer _____

Employer's Address_____

If patient is a minor or dependent, please complete the following information:

Responsible Party _____ Relation to Patient _____

Home#_____ Work #_____ Cell #_____

Primary Insurance (A copy of your insurance card is required)

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____

Social Security Number _____ Relation to Patient _____

Employer Name _____

Secondary Insurance (A copy of your insurance card is required)

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____

Social Security Number _____ Relation to Patient _____

Employer Name _____

Emergency Contact

Name _____ Relation to Patient _____

Home#_____ Work #_____ Cell #_____

Consent for Treatment

The signature below serves as consent for services/treatment/referrals to be rendered by SouthCoast Health for the above named patient. This also authorizes the practice to release or receive protected health information for the purpose of treatment, payment, or health care operations necessary for such services.

_____ _____

Patient (or legal guardian) signature Date

_____ _____

If legal guardian, print name Relation to Patient

How did you hear about SouthCoast Health?

☐ Word of Mouth ☐ Newspaper ☐ Yellow Pages ☐ Physician Referral ☐ Internet Other_____

Patient Contact Information

Patient Name _____Date of Birth_____

Contact Name _____Relationship_____

Phone Number 1: _____ Phone Number 2: _____

Full Disclosure

I, _____, hereby grant permission for SouthCoast Health to contact, disclose and discuss my health information with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Appointments Only

I, _____, hereby grant permission for SouthCoast Health to contact, disclose and discuss my health in information relating to appointments only; requesting, changing and canceling with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

Insurance and Billing Only

I, _____, hereby grant permission for SouthCoast Health to contact, disclose and discuss my health in information relating to insurance and billing issues with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which became effective April 14, 2003.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____