

Patient Profile

Doctor: _____

Patient Information

Name: _____

Patient ID #: _____ Sex: Male Female

Address: _____

Date of Birth: _____

Social Security #: _____

City, State: _____

Marital Status: Married Single Divorced

Zip Code: _____

Referring Physician: _____

Phone: _____ Home Work Other

Primary Physician: _____

Phone: _____ Home Work Other

Patient Employment:

Emergency Contacts

Employed Retired Other

Phone: _____

Employer: _____

Responsible Party

Employment

Address

Same as Patient:

Employer: _____

Name: _____

Phone: _____

Address: _____

Phone: _____

City, State: _____

Social Security #: _____

Zip Code: _____

Date of Birth: _____

Primary Insurance

Company: _____

Relationship to Patient: _____

Insured Party: _____

Social Security #: _____

Policy Number: _____

Secondary Insurance

Company: _____

Relationship to Patient: _____

Insured Party: _____

Social Security #: _____

Policy Number: _____

I hereby authorize assignment and payment directly to Coastal Rehabilitation Medicine Associates, P.A., any major medical benefits due to me. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I understand that my insurance is an agreement between me and my insurance company and I am ultimately responsible for all charges. I understand that my account may be turned over to a collection agency should my balance still be outstanding after 90 days. My signature also authorizes release of my Medical records.

Signature: _____

Date: _____