Patient Registration (Please Print Clearly)

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 Medical Group 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 Medical Group?

☐ 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 Medical Group 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 Medical Group 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 Medical Group 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 _____________________