# PATIENT REGISTRATION INFORMATION

**LAST** NAME:_____ **FIRST** NAME:_____ **MI**:_____

SOCIAL SECURITY #_____ BIRTHDATE :____/____/____MARITAL STATUS_____CA DRIVER'S LIC#:_____

ADDRESS:_____CITY:_____STATE/ZIP:_____

CELL #:_____HOME PHONE:_____WORK PHONE #:_____ E-MAIL:_____

CONSENT TO DISCLOSE my Medical/Financial Information with: _____, relationship _____

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REFERRING/PRIMARY CARE MD:_____PHONE: _____

PHARMACY:_____ PHONE: _____ ADDRESS / CITY: _____

CAC Office Staff:
**ID:** DL# _____ **OR** Utility (Name/Acct#):_____ Address Verified (initial)_____

**PARENT/SPOUSE/RESPONSIBLE PARTY** ***(FILL OUT ONLY WHERE DIFFERENT FROM PATIENT)***

HUSBAND/FATHER:_____ WIFE/MOTHER:_____

ADDRESS:_____ ADDRESS:_____

CELL PHONE:_____BIRTHDATE:_____ CELL PHONE:_____BIRTHDATE:_____

SOC SEC#:_____SOC SEC#:_____

EMPLOYER:_____ WORK PHONE:_____ EMPLOYER:_____WORK PHONE:_____

**SECTION BELOW MUST BE COMPLETE TO BILL INSURANCE**

**INSURANCE INFORMATION**

**PRIMARY** INSURANCE :_____ID:_____ EFFECTIVE DATE:_____

**Subscriber Name & Birthdate**:_____RELATIONSHIP TO PATIENT:_____

PPO / EPO ❒ Medicare ❒ Tricare ❒ VCHCP ❒ DHMN-V (prev ValleyCare IPA ❒ HMO ❒ (We Do NOT Accept)

***HOW DID YOU HEAR ABOUT COASTAL ALLERGY CARE?***_____

FRIEND OR RELATIVE FOR EMERGENCY CONTACT (NOT LIVING WITH YOU):_____

ADDRESS:_____DAYTIME PHONE:_____

The practice of Coastal Allergy Care will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to Coastal Allergy Care. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to Coastal Allergy Care for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments / co-insurance
- Annual deductibles
- Services that are not covered by your health plan
- Interest charges from overdue patient due balances

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE ABOVE NOTED INSURANCE COMPANY(S) BE MADE DIRECTLY TO COASTAL ALLERGY CARE, INC., FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE, INCLUDING DEDUCTIBLE AND COPAYMENTS. ***A $50.00 FEE WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT A MINIMUM OF 24 BUSINESS HOURS NOTIFICATION.*** I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED. ***I ACKNOWLEDGE RECEIPT OF CAC PRIVACY PRACTICES.*** I WILL NOTIFY CAC OF ANY INSURANCE CHANGE

**SIGNED**:_____DATE:_____