

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 _____