Coastal Healthcare PATIENT INFORMATION

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

Patient Name: _____ Patient/Guardian Email: _____

OK to use email and/or text for appointment confirmation?

EMAIL ____Yes ___No TEXT _____ Yes ____No

OK to leave message at

____ HOME	____Brief	or	____Extended	_____
____ CELL	____Brief	or	____Extended	_____
____ WORK	____Brief	or	____Extended	_____

Race: (Check one below)

_____ American Indian or Native Alaskan
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Other Race
_____ Other Pacific Islander
_____ Unreported or refused to report

Ethnicity: (Check one below)

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report

Language other than English:

_____

PATIENT EMPLOYMENT INFORMATION

Employer address:_____ City_____ Zip_____
Employer Phone number:_____

PHARMACY INFORMATION

Please list your preferred Local and Mail Order Pharmacy. Prescriptions will be done electronically ☐ ☐ directly

LOCAL PHARMACY:

Name:_____
Address:_____
City:_____Zip_____
Phone #_____
Fax: _____

MAIL ORDER PHARMACY:

Name:_____
Address:_____
City:_____Zip_____
Phone #_____
Fax: _____

ERx History Consent:

I hereby give **Coastal Healthcare** and its affiliated providers permission to view my prescription information and history from all external sources. By signing this consent form, I agree that **Coastal Healthcare** can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for all treatment purposes.

Patient Signature _____ Date _____