Coastal Healthcare REGISTRATION ADULT

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION ***PRINT*** ***REFERRED BY:*** _____

Last: _____

First_____ MI_____

Previous Name:_____

Address_____

City_____

State_____ Zip_____

Please put an (X) next to your preferred contact number:

Home#_____(__)

Cell #_____(___)

Work #_____Ext _____(___)

PRIMARY CARE DR:_____

Date of Birth_____ AGE _____

Sex: ____Male ____Female

Marital Status: ___Divorced ___Single ___Partner

___Married ___Widowed ___Legally Separated

Social Security #_____

Employer:_____

Employ status: __F/T __P/T __Self-Employ

__Retired __Not Employed __Military

Student: ___F/T ___P/T

PRIMARY INSURANCE	SECONDARY INSURANCE
INS CO _____	INS CO. _____
ID #_____ COPAY $ _____	ID #_____ COPAY $ _____
PT's Relationship: ___Self __Spouse __Child __Partner	PT's Relation: __Self __Spouse __Child __Partner

If Insured is other than patient (self):

Insured name: _____	Insured name: _____
SS#_____ DOB_____	SS#_____DOB_____
Employer:_____	Employer:_____

EMERGENCY CONTACT:

Name:_____ Relationship_____

Address if different than patient: Phone:_____

Street:_____ City_____ Zip_____

LIVING WILL (Advanced Medical Directive) Do you have one? _____ NO _____ YES
If Yes, please provide a copy for your medical records with your doctor.

Private Insurance Authorization Assignment of Benefits/ Informaton Release:
I, the undersigned, authorize payment of a medical benefit to Coastal Healthcare for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

SIGNATURE:_____ DATE:_____

Medicare Lifetime Signature of File:

I request that payment of authorized Medicare benefits be made on my behalf to Coastal Healthcare for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents and Medigap insurers, any information needed to determine these benefits or any other benefits payable for related services.

SIGNATURE:_____ DATE:_____

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 _____

Coastal Healthcare

Patient History Form — Completed by Patient

Name:_____ Date of Birth: _____

Reason for Visit: _____

ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____

Do you smoke? _____ Packs per day: _____

Do you drink? _____ How often: _____

PAST MEDICAL HISTORY

Please list your significant illnesses and when they were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS SURGERY

Please provide approximate date.

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY

Please list any significant illnesses of your grandparents, parents, siblings, and children.

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Signature: _____ **Date:** _____

Coastal Healthcare

Patient Medication Form Completed by Patient

Name:_____ Date of Birth: _____

MEDICATIONS

Please list all medications including non prescription and over the counter items such as vitamins that you take on a regular basis.
Include the name, dose and frequency with which you take it.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

TREATING PHYSICIANS

Please list all your current physicians

Ophthalmologist (Eye): _____
Nephrologist (Kidney): _____
Podiatrist (Feet): _____
Other: _____

Patient Signature: _____ **Date:** _____

Coastal Healthcare

Patient Review of Systems — Completed by Patient

Name:_____ Date of Birth: _____

Constitutional Symptoms	Yes	No	Cardiovascular	Yes	No	Respiratory	Yes	No
Fever			Chest Pain			Wheezing		
Chills			Palpitations			Frequent Cough		
Weight Gain			**Musculoskeletal**			Shortness of Breath		
Weight Loss			Joint Pain			**Neurological**		
Fatigue			Back Pain			Headache		
Eyes			Muscle Pains			Tremors/Hands Shaking		
Blurred Vision			**Ear/Nose/Throat/ Mouth**			Dizziness		
Double Vision			Difficulty Swallowing			Numbness/Tingling		
Skin			Ear Infection			**Gastrointestinal**		
Skin Rash			Sore Throat			Abdominal Pain		
Dry Skin			Sinus Problems			Nausea/Vomiting		
Hair Loss			Nose Bleeds			Heartburn		
Endocrine			Swollen Neck Glands			Loss of Appetite		
Excessive Thirst			**Genitourinary**			Diarrhea		
Heat Intolerance			Painful Urination			Constipation		
Cold Intolerence			Frequent Urination			**Psychological**		
Change in Hat/ Glove Size						Depression		
						Insomnia		
						Anxiety		

Patient Signature: _____ Date: _____

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE FORM

1. **<u>Acknowledgement of Privacy Practice Notice</u>:**
   I have been offered a copy of ***Coastal Healthcare's*** Notice of Privacy Practices.

   Patient Name: _____ Date of Birth_____

2. **<u>I wish to be contacted in the following manner (check all that applies)</u>:**

   Home Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

   Cell Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

   Work Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

   Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. ***Coastal Healthcare*** operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **<u>Designation of Certain Relatives, Close Friends and Other Caregivers</u>:**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (<u>other than patient</u>) 1) _____ 2) _____

Relationship to Patient: 1) _____ 2) _____

Date of Birth: 1) _____ 2) _____

Telephone #: 1) _____ 2) _____

_____ _____
Signature of Patient/Parent/Guardian Date

Coastal Healthcare

FINANCIAL POLICY

Welcome to Coastal Healthcare. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. If your insurance company requires referrals, advanced notification is required for non-emergent referrals. Also, when coming to a Coastal Healthcare specialist, you must have your referral before being seen or you will be responsible for payment in full at the time of service. We accept payment from all participating insurance plans, but require that you pay your co-pay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
All missed appointments with the doctor and those cancelled with less than 24-hour notice may be subject to a $25.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge. There may be additional charges, not covered by insurance, including form processing fees (i.e., physicals, disability), after-hours appointments, weekend appointments, appointments on holidays, and a processing fee on over 30 day unpaid balances ($10 per statement).

Collection Agency:
All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.

Financial Hardship:
Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY.

_____ _____

Patient Name-Please Print Date

_____ _____

Patient or Parent Signature Relationship

ADVANCED ENDOCRINOLOGY AND WEIGHT MANAGEMENT
180 WHITE ROAD, SUITE 204
LITTLE SILVER, NJ 07739

OFFICE POLICY

1. Prior Authorization

Some medications and imaging studies require prior authorization. Usually insurance company takes up to 1-2 weeks to process these requests. We will contact you once they are approved.

2. Results

Bloodwork and imaging (ultrasound/CT/MRI) results are not discussed on the phone. You will be asked to schedule appointment to discuss the results with the physician.

3. Follow up visit

You should follow up as instructed by the physician to ensure that we can provide appropriate care for your condition. Three missed/cancelled appointments may lead to discharge from the practice, as we can not ensure that we will be able to provide adequate treatment for your condition.

4. Refills

Please call your pharmacy to request the refill.

Prescriptions will be refilled for only 1 month if patient can not show up for the required follow up visit for any reason and further refills will not be made unless the patient is seen.

_____ _____

Patient's signature Date