COASTAL FOOT AND ANKLE CLINIC
WELCOME

PATIENT INFORMATION :

DATE_____

NAME
LAST_____FIRST_____ MI___

SEX MALE____ FEMALE_____

DATE OF BIRTH_____

SPOUSE'S NAME_____

EMPLOYER_____

CONTACT NUMBERS:

HOME_____ WORK_____

CELL_____ OTHER_____

RACE:

WHITE____ ASIAN_____

AMERICAN INDIAN/ALASKA NATIVE_____

BLACK/AFRICAN AMERICAN_____

NATIVE HAWAIIAN/PACIFIC ISLANDER_____

ETHNICITY:

HISPANIC/LATINO____NON HISPANIC/LATINO___

LANGUAGE

ENGLISH___ SPANISH____ OTHER_____

CONTACT BY: PHONE____MAIL_____E-MAIL____

SPOUSE_____ FAMILY_____ VOICEMAIL_____

EMAIL_____
(This will enable you to access your medical records through our online portal) YOU WILL NOT RECEIVE SPAM MAIL

ADDRESS: _____

CITY_____STATE_____ZIP_____

SSN: _____-_____-_____

GUARANTOR: SELF___ SPOUSE___ OTHER_____

SMOKER: NEVER___ FORMER_____

SOME DAYS_____ EVERY DAY _____

REFERRED BY _____

ASSIGNMENT AND RELEASE: I the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Marsh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship_____ Date_____

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Marsh to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremity.

Patient Signature_____Date_____

Parent/Guardian_____Date_____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Marsh for any services furnished me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurances and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature_____Date_____

The original medical records/x-rays contained in Dr. Marsh's patient charts will not be released from these premises under any circumstances.

Patient Signature_____Date_____

THIS OFFICE HAS A "NO TOLERANCE " DRUG POLICY. DR. MARSH RARELY WRITES PRESCRIPTIONS FOR NARCOTICS.