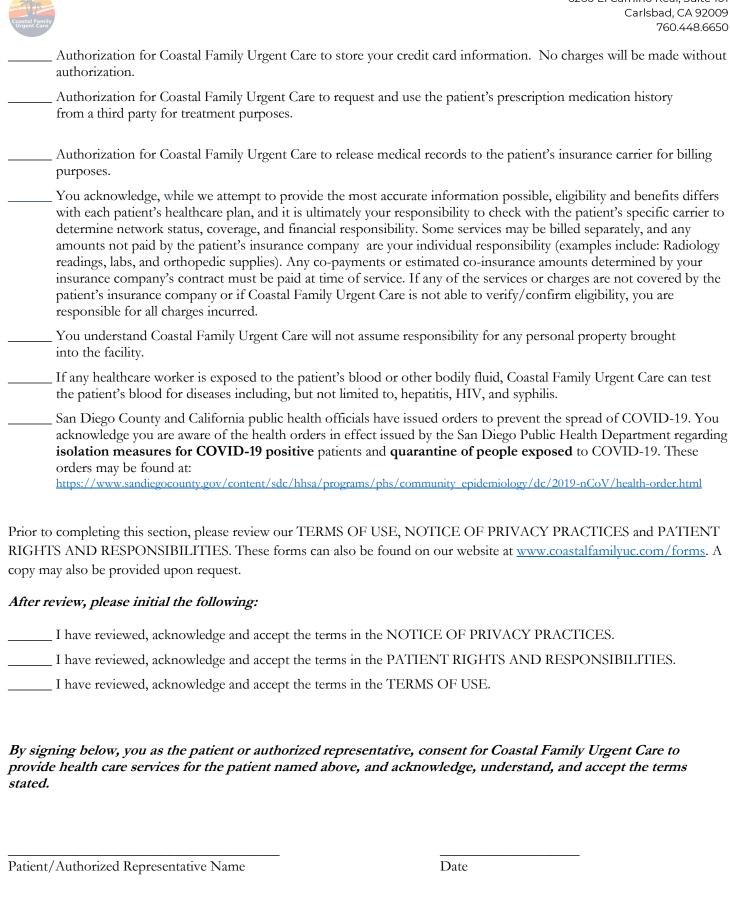


PATIENT INTAKE FORM – Coastal Family Urgent Care

PATIENT INFORMATION		
Patient Name:		Sex: [] Male [] Female
Address:		
City:	State:	Zip Code:
Date of Birth:	_ SS (For military insurances):	
Phone Number:	Email:	
Preferred pharmacy:	City:	Zip Code:
Preferred language:		
EMERGENCY CONTACT		
Emergency Contact Name:		
Relationship:	Phone Number	c
RESPONSIBLE PARTY (Must be pare		
Name:	Relationship:	
[] Same as above Address:		
		Zip Code:
Date of Birth:	_ SS (For military	insurances):
Phone Number:	Email:	
INSURANCE INFORMATION		
[] Self Pay [] He	ealth Insurance Provider:	
Healthcare Plan:	Member ID:	
Reason for visit:		
icason for visit.		
How did you hear about us? [] Go	ogle [] Yelp [] Handou	t [] Friend [] Insurance Website
•		Other:
	t J	
Please review carefully. Your initials in	ndicate your acknowledgement and	d permission for the following:
Anoth animation to leave we isometile	on the phone number provided whi	ah may agatain nawanal madiaal information
This information may include, bu	it is not limited to, demographic infor	ch may contain personal medical information. mation (patient name, date of birth, address, diagnosis, medications, test results, etc.).
are not able to do so through our information (patient name, date of dates, diagnosis, medications, test	patient portal. This information may of birth, address, etc.), billing informat t results, etc.). Communications via en possibility information included in an	y contain personal medical information, if we y include, but is not limited to, demographic tion, and medical information (appointment mail over the internet may not be secure. email can be intercepted and read by other



Patient/ Authorized Representative Signature