COASTAL CAROLINA OTOLARYNGOLOGY

Patient Information

Last Name: ______________________ First Name: ____________________ Middle: ________

Date of Birth: ______________ Age: ________ Sex: M F Marital Status: M S D W

Social Security Number: __________________________ Race: ______________________

Mailing Address: ______________________________________ Apt/Unit Number: ________

City: ______________________________ State: __________ Zip Code: ____________

Home Phone: ______________ Cell Phone: ________________ Work Phone: ______________

Preferred Local Pharmacy and Location: ____

Guarantor/Guardian (If patient is under 18)

Last Name: ______________________ First Name: ____________________ Middle: ________

Date of Birth: ______________ Sex: M F Social Security Number: ____________________

Relationship to Patient: ____

Legal Guardian: Yes No ***Legal Guardianship Documentation is Required at Time of Service***

Insurance Information

Primary Insurance: ____

Secondary Insurance: ____

Tertiary Insurance: ____

Insured Information (If primary cardholder is other than the patient)

Last Name: ______________________ First Name: ____________________ Middle: ________

Date of Birth: ______________ Sex: M F Social Security Number: ____________________

Relationsip to Patient: ____

*I authorize the release of any medical or other information necessary to process insurance claims

*I authorize payment of medical benefits directly to this practice for services rendered.

*Services rendered to you that are not covered by your insurance carrier are your financial responsibility.

Signature: ______________________________________ **Date:** ________________