

1124 Burnside Ave.
Gonzales, LA 70737
Ph. 225-644-5503
www.CoastalUC.com



Please **NOTIFY STAFF** if you have an emergency such as: **CHEST PAIN, a HEAD INJURY, SHORTNESS OF BREATH, SEVERE ABDOMINAL PAIN, or the WORST HEADACHE OF LIFE** before continuing.



Is this visit the result of an accident? Yes No

Did this accident occur at work? Yes No

Patient Last Name _____ First Name _____ M. Name + Suffix _____

Sex _____ Date of Birth: _____ SSN _____

Home Phone _____ Cell Phone _____

Street Address / P.O. Box _____ Apt. / Lot # _____

City _____ State _____ Zip _____

Marital Status S M D WD

Email _____ No Email

GUARANTOR (Person Responsible for bill) same as patient above

Relationship to patient Spouse Child Other _____

Last Name _____ First Name _____ M. Name + Suffix _____

Street Address/P.O.Box _____

City _____ State _____ Zip _____

Date of Birth _____ SS # _____ Phone _____

PRIMARY INSURANCE Name of Ins. _____

Patient's Relationship to Policy Holder Self Spouse Child Other _____

Last Name _____ First Name _____ M. Name + Suffix _____

Policy # _____ Date of Birth _____ SS # _____

SECONDARY INSURANCE Name of Ins. _____

Patient's Relationship to Policy Holder Self Spouse Child Other _____

Last Name _____ First Name _____ M. Name + Suffix _____

Policy # _____ Date of Birth _____ SS # _____

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. Coastal Urgent Care is contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with, including Medicaid. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service.

It is important for you to understand that the patient is ultimately responsible for knowing their individual benefits/coverage and is responsible for any fees that are not covered by their insurance provider, including durable medical equipment (splints, crutches, ace wraps, etc). If you have any questions concerning the coverage your plan has with Coastal Urgent Care, please contact your insurance provider.

I have reviewed and agree with the above information. I certify that the information I have provided is true and correct to the best of my knowledge.

Patient Signature (if minor, signature of parent/guardian)

Date

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Coastal Urgent Care, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name, relationship and a personal identification method of persons you wish to allow access – for example:

Name:

John Doe

Relationship:

Father

Personal Identification:

Date of Birth, Address or last 4 of SS #

Restriction Request: _____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Coastal Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ Date _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

Date of Birth of Personal Representative _____ Last 4 of SS# _____

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: _____

parent or guardian of minor patient
guardian or conservator of an incompetent patient



Room #: _____

Patient's Name: _____ Age: _____ DOB: _____

Phone: _____ Email: _____

Ht: _____ Wt: _____ LBS KG

Vital Signs: BP- _____ Pulse- _____ Resp.- _____ **LMP:** _____

Temp.- _____ Pulse Ox- _____

Complaint: _____

Onset: _____ days/weeks/months

Allergies: _____

Medications: _____

Past Med/Surg History: _____

Family History: Mother _____

Father _____

Smoke/Drink/Drug Use

Strep _____

Occupation: _____

FLU _____

Immunizations: Up to Date: Y N

Decadron ___mg

Last Tetanus Date: _____

Toradol ___mg

Celestone ___mg