The Center for Women's Health
COASTAL IMAGING LLC

Patient Information Form

Date:_____

☐ Male ☐ Female

Name:_____ Date of Birth:_____SSN:_____

Mailing Address:_____

City:_____ State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell phone:_____

Email: _____

Name of Parent/Guardian (for minors only):_____Phone:_____

Address (if different from patient):_____

Emergency Contact Name:_____Contact Number:_____

Patient Guarantor Employer Information

Employer's Name:____ _____Address:_____
Occupation:_____Phone:_____

Responsible Party

Primary Insurance:_____SecondaryInsurance:_____

Assignment and Release:

The signature below serves as authorization for the release of medical information from patient's other healthcare providers for purpose of treatment and for services rendered by The Center for Women's Health for the above named patient. This signature will also serve as a release of information necessary to file insurance and assign benefits otherwise payable to policy holder, to the physician or group indicated on the claim. I authorize direct payment from my insurance company to Coastal Imaging. I understand I am financially responsible for any balance not covered by the insurance carrier.

We will file non-contracted insurance as a courtesy: however, if we have no response from your insurance company within 60 days, the charges will be transferred to your responsible party.

Signature:_____Date:_____

For office use only:_____Date:_____