Coastal Pain &
Spinal Diagnostics

Registration

Patient Legal Name_____D.O. B _____ Sex_____

Email _____ ☐ Yes, I would like to access to the online patient portal

SS#_____Marital Status_____Phone _____ Cell _____

Emergency Contact_____Phone _____Relationship _____

Current Employer_____Occupation_____

Spouse Name_____Spouse Employer_____

Referring Physician_____Phone #_____

Primary Care Physician_____Phone #_____

Primary Insurance_____Phone # _____ID#_____

Subscriber Name_____Subscriber SS#_____Subscriber DOB _____Group # _____

Secondary Insurance_____Phone # _____ID#_____

Subscriber Name_____Subscriber SS#_____Subscriber DOB _____Group # _____

Work Comp Carrier Name_____Phone # _____
Claims Address_____City_____State_____Zip_____
Claim # _____DOI _____Primary Treating Physician _____

Type of Injury _____Adjuster _____Phone # _____

Employer at time of injury _____Phone #_____ Attorney Phone #_____

I understand that patients with medical insurance professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I commit to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. If my account is referred for outside collection, I may be charged a service charge. If a legal settlement occurs on my behalf (i.e. PI Claim) for services rendered by Coastal Pain & Spinal Diagnostics Medical Group, Inc. and a refund is requested by my private insurance carriers(s), I acknowledge and understand that I hold full financial responsibility for all billed charges during the affected service date(s).

AUTHORIZATION: I hereby authorize payment directly to Coastal Pain & Spinal Diagnostics Medical Group, Inc for medical services rendered and to release any information acquired during my examination or treatment to my insurance company and/or referring entity. I also acknowledge and understand that I am solely responsible for keeping my account current and accurate at all times with Coastal Pain & Spinal Diagnostics Medical Group, Inc which includes demographics, insurance information and balances due. Failure to notify Coastal Pain & Spinal Diagnostics Medical Group of updates to account may result in being financially responsible for all services rendered.

Patient's / Guardian's Signature_____Date _____

Witness if signed by someone other than patient _____