

COASTAL SPORTS & WELLNESS MEDICAL CENTER

New Patient Information			
Name (Last, First, Middle)		SSN #	
Street Address		Suite/Apt	Birth Date
City	State	Zip Code	
Email	Home #	Work #	Cell #
Occupation		Employer	
Sporting Activities		Marital Status	

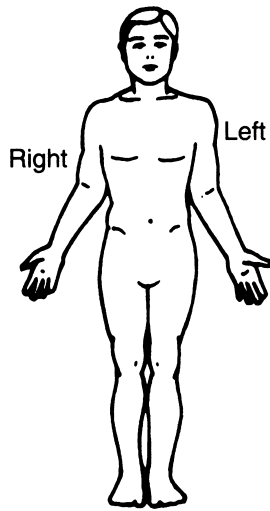
Insurance Information			
Insurance Company			
Name of Insured		SSN #	Birth Date
Street Address		Suite/Apt	
City	State	Zip Code	
Email	Home #	Work #	Cell #

Legal Information	
Financial Policy	Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan are your responsibility.
Consent to Treat	I grant Coastal Sports & Wellness, Inc , a California medical corporation doing business as Coastal Sports and Wellness Medical Center to administer medical treatment and perform medical procedures and deemed necessary.
Release of Information, Arbitration Agreement and Privacy Policy	<p>I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. I also grant permission for Coastal Sports & Wellness, Inc to request my medical records and tests from other treating physicians, clinics and hospitals pertaining to my medical care at this office. I also authorize Coastal Sports and Wellness, Inc to release medical information to other medical professionals as required for my medical care at Coastal Sports & Wellness Medical Center.</p> <p>I acknowledge that I have received a copy of Coastal Sports & Wellness, Inc. privacy policy regarding medical information and arbitration agreement.</p>
Assignment of Benefits	I hereby assign all benefits payable by my insurance company to Coastal Sports & Wellness, Inc , a California medical corporation.
Signature of Patient/ Guardian	X _____ Date _____

Patient Name _____

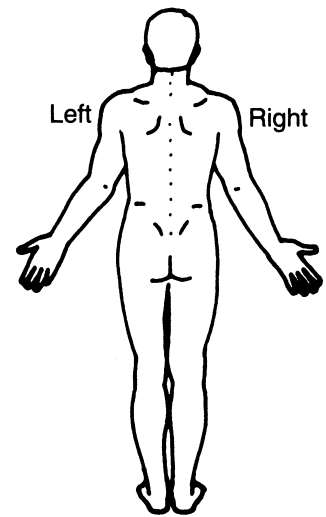
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Reason for Today's Visit	
Reason:	
If Injury or illness, please fill out below	
Location	Duration (When did it first start? How long does it last?)
Severity (Mild, moderate, severe)	Quality (Sharp, dull, burning, shooting)
Timing (When do symptoms occur?)	Context (Situations associated with pain)



Please indicate areas of complaint with these symbols:

- ✓ Pain
- Numbness
- ✕ Tingling



Medical and Social History					
Current Medical Problems					
Current Medications					
Prior Surgeries					
Allergies					
Do you smoke?	Yes/No	How Much? _____	Do you drink alcohol?	Yes/No	How Much? _____

Family History	Age	Medical Problems
Father	_____	_____
Mother	_____	_____
Brothers/Sisters	_____	_____
Spouse	_____	_____
Children	_____	_____

Patient Name _____