9808 Bluebonnet Blvd.
Baton Rouge, LA 70810
Ph. (225) 224-8121
Fax (225) 442-1927
coastalurgentcarebatonrouge.com

Coastal URGENT CARE
Baton Rouge, Gonzales, Houma, Thibodaux, Bossier

REF ID _____

STOP **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.** STOP

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

Language _____ Race _____ Ethnicity _____

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

POS® Reorder # 1313634

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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:	**Relationship:**	**Personal Identification:**
John Doe	Father	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 PrivacyPractices.

_____ _____ _____

Signature of Patient or Personal Representative | Date | 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

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Baton Rouge, Gonzales, Houma, Thibodaux, Bossier

STAFF ONLY

Room # _____

Patient Name: _____ Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Height - _____ (inches)	Weight - _____ (LBS) _____ (KG)	Last Menstrual Period: _____

Complaint: _____

Onset: _____ ☐ hours / ☐ days / ☐ weeks

Alergies: _____

Medications: _____

Past Med / Surg History: _____

Family History:

Mother: _____

Father: _____

☐ Passive Smoke Exposure	
☐ Nonsmoker	☐ Do not drink alcohol
☐ Former Smoker Years smoked:	☐ Occasional Drinker
☐ Circle One: Occasiona l/ Daily Smoker Years smoked:	☐ Daily Drinker

Occupation: _____ School Grade: _____ Day Care: ☐ Y ☐ N

Vital Signs (Staff Only)

BP -	Pulse -	Resp-	Immunizations up to date: ☐ YES or ☐ NO		
Temperature: _____ (Oral / Ax / Rectal)		%02 _____	Tetanus up to date: ☐ YES or ☐ NO		
Strep -	Flu -	UA / UPT -	Celestone ____ mg	Toradol _____ mg	Decadron _____ mg