COASTAL HARBOR HEALTH SYSTEM
COASTAL HARBOR TREATMENT CENTER • COASTAL BEHAVIORAL HEALTH
SAVANNAH, GA

REGISTRATION INFORMATION

DOCTOR:	
DIAGNOSIS:	
PROGRAM:	
TIME:	
PATIENT #:	

TODAY'S DATE:

Thank you for choosing Coastal Harbor Health System. Our counselors will meet with you for a free assessment and discuss your needs and available alternatives. In order to assist you and your family in identifying available resources, please completed the following information.

PATIENT INFORMATION

NAME, (FIRST, MIDDLE, LAST)				**SSN**
ADDRESS				
CITY		**STATE**	**ZIP CODE**	**COUNTY**
MARITAL STATUS	**DATE OF BIRTH**	**AGE**	**GENDER**	**HOME PHONE** (with area code)
GUARDIAN/SPOUSE	**HOME PHONE** (with area code)	**WORK PHONE** (with area code)		**CELL PHONE** (with area code)
EMERGENCY CONTACT	**RELATIONSHIP**	**HOME PHONE** (with area code)		**WORK PHONE** (with area code)
ADDRESS		**CITY, STATE**		**ZIP CODE**

INSURANCE INFORMATION

INSURED NAME	**INSURED SSN**		**INSURED DATE OF BIRTH**
IS PATIENT INSURED? ☐ **YES** ☐ **NO**	**INSURANCE COMPANY**	**PREFERRED EMERGENCY HOSPITAL** ☐ MEMORIAL ☐ CANDLER/ ST JOSEPH'S ☐ ANY ☐ OTHER: _____	**INSURANCE CO. PHONE** (with area code)
EMPLOYER			☐ **SALARY** ☐ **HOURLY**
EMPLOYER ADDRESS			☐ **EMPLOYEE** ☐ **DEPENDENT**
CITY	**STATE**	**ZIP CODE**	**EMPLOYER PHONE** (with area code)
TITLE / DEPARTMENT	**EMPLOYEE ID NUMBER**	**LENGTH OF EMPLOYMENT** _____ **YRS /** _____ **MOS**	

HOW DID YOU KNOW TO CALL COASTAL HARBOR HEALTH SYSTEM?

This consent is subject to revocation at any time except to the extent that action has been taken thereon. This consent will expire after the action is completed.

I, _____, give the Needs Assessment Staff at Coastal Harbor Health System permission to perform an assessment and permission to verify insurance benefits to assist with referral services.

X _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN

ADMINISTRATION: FILE IN ADMISSIONS AND BUSINESS OFFICE