



DOCTOR:	
DIAGNOSIS:	
PROGRAM:	
TIME:	
PATIENT #:	

REGISTRATION INFORMATION

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY		INSURANCE CO. PHONE (with area code)
EMPLOYER			<input type="checkbox"/> SALARY <input type="checkbox"/> HOURLY
EMPLOYER ADDRESS			<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> DEPENDENT
CITY		STATE	ZIP CODE
TITLE / DEPARTMENT		EMPLOYEE ID NUMBER	EMPLOYER PHONE (with area code)
		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