

5314 Airline Dr
Bossier City LA 71111
Ph. (318) 678-5272
www.coastalurgentcarebossier.com



REF ID _____



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.



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



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: John Doe	Relationship: Father	Personal Identification: Date of Birth, Address or last 4 of SS#
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_____	_____	_____
_____	_____	_____

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 Privacy Practices.

_____	_____	_____
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



STAFF ONLY

Room: _____

Triage Time: _____

MR #: _____

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

Medication Allergies: _____

Medications Taking: _____

Is this visit a result of a work related accident? Yes / No Have you been a patient here before? Yes / No

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anemia	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Seizures
<input type="checkbox"/> ADHD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Anxiety / Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> List Other: _____
<input type="checkbox"/> COPD	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> NO PAST MEDICAL HISTORY		_____

PAST SURGERIES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gall Bladder removal	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Cardiac Stent	<input type="checkbox"/> Tubes in ears	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Tonsillectomy/Adenoidectomy
<input type="checkbox"/> C-Section	<input type="checkbox"/> Hernia repair _____	<input type="checkbox"/> List Other: _____
<input type="checkbox"/> NO PAST MEDICAL HISTORY	_____	_____

SOCIAL HISTORY

<input type="checkbox"/> Parent smokes (pediatric patients only)	
<input type="checkbox"/> Nonsmoker	<input type="checkbox"/> Do not drink alcohol
<input type="checkbox"/> Former Smoker Years smoked: _____	<input type="checkbox"/> Occasional Drinker
<input type="checkbox"/> Circle One: Occasional/Daily Smoker Years smoked: _____	<input type="checkbox"/> Daily Drinker

CURRENT SYMPTOMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL	PULMONARY	PAIN / INJURY
<input type="checkbox"/> Fever (Max: _____)	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Back pain
<input type="checkbox"/> Chills	<input type="checkbox"/> Cough	<input type="checkbox"/> Headache
<input type="checkbox"/> Body Aches	CARDIOVASCULAR	<input type="checkbox"/> Location: _____
HEENT	<input type="checkbox"/> Chest pain, NOTIFY STAFF!	GU
<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Passed out	<input type="checkbox"/> Burning with urination
<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Skin Problems (Rash)	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Laceration	<input type="checkbox"/> List Other: _____
<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Abscess (Boil)	_____
WHEN DID SYMPTOMS START? (Use a number)	minutes ago	hours ago
		days ago
		weeks ago

Vital Signs (Staff Only)

BP - _____	Pulse - _____	RR - _____	Pulse ox - _____	Immunizations up to date: YES or NO
Temperature: _____ (Oral / Ax / Rectal)				Tetanus up to date: YES or NO
Height - _____ (inches)	Weight - _____ (LBS) _____ (KG)		Last Menstrual Period: _____	
Pharmacy:				
Strep - _____	Flu - _____	UA / UPT - _____	Celestone ____ mg	Toradol ____ mg
			Decadron ____ mg	