Coastal Family Practice and Internal Medicine, LLC

1004 South Old Dixie Hwy, Suite #201, Jupiter, FL 33458
(Ph) 561-284-8383 (Fax) 561-284-8380

Due to government regulation, we will need a copy of your insurance cards and photo ID to protect your identity

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address:_____

City: _____ State: _____ Zip: _____

Preferred Phone #: _____ Secondary #:_____

Birth Date: _____ Soc Sec #:_____

E-mail Address: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single

Ethnicity: □ African American □ Asian □ Caucasian □ Hispanic □ Other

Emergency Contact Name:_____ Relationship:_____

Emergency Phone #:_____

Occupation:_____ Employer Name: _____

Work Address/Phone #_____/_____

Preferred Pharmacy:

Name:_____ Phone #: _____

Location:_____

Billing:

Fees for services rendered are responsibility of the patient, regardless of insurance coverage. Forms will be completed as necessary to facilitate insurance carrier payments. Unpaid balances, after 120 days, will be turned over to a collection agency. The patient is then responsible for the balance, accrued interest, and collection/attorney fees.

Signature (Patient or Parent Guardian): _____ Date: _____