

COASTNEURO
2 James Way, Suite 101 Pismo Beach, CA
PATIENT REGISTRATION

Patient Name _____ Birth Date _____

Home Address _____ City _____ State _____ Zip _____

Billing Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Social Security No _____ Driver's License No _____

Gender _____ Language _____ Marital/ Relationship Status _____

Spouse/ Partner Name _____ Email (appt. reminders) _____

Emergency Contact _____ Phone Number _____

(Required by Federal Law)

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refuse to Report

Race: American Indian or Alaska Natives Asian Hispanic White

Black or African American Native Hawaiian or Other Pacific

Unreported/ Refuse to Report Other Pacific Islander Other Race

Insurance Information

Name of Insured _____ Relationship to Patient _____

Soc. Sec. No. of Insured _____ Birth Date of Insured _____

Primary Insurance _____ ID No _____ Group No _____

Secondary Insurance _____ ID No _____ Group No _____

Physician & Pharmacy Information

Referring Doctor _____

Primary Care Doctor _____

Pharmacy _____

Please give your insurance card(s) and driver's license to the receptionist.
The most current version of this form is always available at www.coastneuro.com