1009 S. Service Rd. W
Ruston LA 71270
Ph. (318) 242.1440
www.coastalurgentcareruston.com

Coastal URGENT CARE

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 consent to receive automated reminders sent to my mobile phone Via Call and/or text message. 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

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

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 PrivacyPractices.

_____ _____ _____

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

Coastal URGENT CARE

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)

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

PAST SURGERIES (PLEASE CHECK ALL THAT APPLY)

☐ Appendectomy	☐ Gall Bladder removal	☐ Hysterectomy
☐ Cardiac Stent	☐ Tubes in ears	☐ Thyroidectomy
☐ Heart Bypass	☐ Tubal ligation	☐ Tonsillectomy/Adenoidectomy
☐ C-Section	☐ Hernia repair _____	☐ List Other: _____
☐ NO PAST MEDICAL HISTORY		

SOCIAL HISTORY

☐ Parent smokes (pediatric patients only)	
☐ Nonsmoker	☐ Do not drink alcohol
☐ Former Smoker Years smoked:	☐ Occasional Drinker
☐ Circle One: Occasional/Daily Smoker Years smoked:	☐ Daily Drinker

CURRENT SYMPTOMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL	**PULMONARY**	**PAIN / INJURY**
☐ Fever (Max:)	☐ Shortness of breath	☐ Back pain
☐ Chills	☐ Cough	☐ Headache
☐ Body Aches	**CARDIOVASCULAR**	☐ Location:
HEENT	☐ Chest pain, NOTIFY STAFF!	**GU**
☐ Eye Problems	☐ Passed out	☐ Burning with urination
☐ Ear Problems	☐ Skin Problems (Rash)	☐ Frequent Urination
☐ Sore Throat	☐ Laceration	☐ List Other: _____
☐ Sinus Congestion	☐ 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