Shoreline Surgical Associates, P.C.

Joseph A. Coatti, M.D. Jonathan D. Blancaflor, M.D.
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General Information

Name: _____/__/_____M/F_____
Last First MI Date of Birth Sex Age

Address: _____
Street City State Zip Code

Phone: (____) _____ (___) _____
Home Cell email address

_____-__-_____ M__S__D__W_____ Height: ____ Weight: _____
Social Security # Marital Status (circle one)

Nearest Relative or Friend: _____(____)_____
(Not living with you) Name Phone Number

Employer: _____ Occupation: _____ Work Phone: (____)_____

Referring Doctor: _____ Family Doctor: _____
Address: _____ Address:_____

Insurance Information

Please remember the copay is your responsibility. Thank you.

Primary Insurance	Secondary Insurance
Name of Insurance: _____	Name of Insurance: _____
Member ID# _____	Member ID# _____
Insured: Self Spouse* Other* (circle one)	Insured: Self Spouse* Other* (circle one)
***Please Complete Info Below**	***Please Complete Info Below**

Insured's Information (If other than self)

_____/__/_____-__-_____
Name Date of Birth SS# Employer

Authorization to pay benefits to Physician and release of information:
I hereby authorize my insurance benefits be paid directly to the Physician and I am responsible to pay for non-covered services, copays, deductibles and any remaining balances. I also authorize the Physician to release any information acquired in the course of my treatment to my insurance company, my company or my primary/referring Physician in writing or by fax.

Patient's Signature _____ Date: _____

Worker's Compensation

Accident/Injury _____Yes No
Employer Name Date of Injury Report of Injury Filed
Injury Description: _____

Contact Person: _____ Billing Address: _____

Name: _____ _____/ /_____
(Last) (First) (M.I.) Date of Birth

Reason for Office Visit: _____

List All Medications
(Over the counter & herbal supplements)

_____
_____
_____
_____
_____

List All Allergies
(Include food, iodine, etc.)

_____
_____
_____
_____
_____

List Prior Hospitalizations
(Include reason/date & surgeries)

_____
_____
_____
_____
_____

Have you ever been diagnosed with, told or experienced any of the following conditions?

Cardiovascular
Heart Attack
High Blood Pressure
Irregular Heart Beat
Ankle Swelling
Chest Pain w/ Exertion
Shortness of Breath
Valvular Disease
Palpitation
Heart Failure
Aneurysm
Leg Cramps
Heart Murmur

Hematological
Bleeding Disorder
Hemophelia
Phelbitis

Respiratory
Chronic Cough
Chronic Bronchitis
Coughing up Blood
Pulmonary Embolism
Hoarseness
Emphysema
Asthma
Allergies
Tuberculosis
Lung Cancer

Endocrine
Diabetes
Adrenal
Parathyroid
Thyroid
Pituitary

Gastrointestinal
Hepatitis
Diverticulitis
Chronic Diarrhea
Constipation
Blood in Stool
Difficulty Swallowing
Jaundice
Gallstones
Peptic Disease
Hernia
Cancer
Bowel Movement Changes

Skin & Musculoskeletal
Arthritis
Chronic Muscle Ache
Nonhealing Ulcers
Back Pain
Bone Pain

Neurological
Stroke
Epilepsy
Seizures
Memory Loss
TIA
Paralysis
Disc Disease
Depression
Alzheimers

General
Fever
Night Sweats
Weight Loss

Breast
Lump
Discharge
Cyst
Cancer
Infection

Other:

_____
_____
_____
_____
_____

Family History:

Mother – Age: _____

Father – Age: _____

Sister (s)– Age: _____

Brother (s) – Age: _____

Social History:

Smoker ? Yes No Packs per day ? _____ Quit ? Yes No When? _____
Drink Alcohol Yes No Socially ? Yes No Excessively ? Yes No Drug Abuse ? Yes No

All information is strictly confidential. Thank you for choosing our office!

Undersigned M.D. has reviewed the above information with patient.

Physician signature: _____ Date: _____