coastal pediatric group

NEW PATIENT ENROLLMENT

91 Mack Bayou Loop
Santa Rosa Beach, FL 32459
(850) 659-6556

PATIENT NAME(S):

Last _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

First _____ Date of Birth _____ Appt Type:_____
Goes by: _____ Male/Female/Other: _____

Address _____ City _____ State ____ Zip _____
Cell Phone _____

To ensure payment from a third party such as an insurance company and/or you do not have insurance, please be aware that we collect a credit card to keep on file. We send an email out to the below first parent/guardian email address 3 days prior to charging the card. If there is any questions or discrepancies, the charge can be paused or stopped by calling the office _____

PARENT/GUARDIAN

Name _____ Relationship to Patient _____
Email _____ Date of Birth _____

ADDITIONAL PARENT/GUARDIAN

Name _____ Relationship to Patient _____

Email _____ Date of Birth _____ Phone:_____

As the parent/guardian filling out this form, upon acceptance into the practice, I give my permission for Coastal Pediatric Group to call, text, or email me with the information I have provided above. You further consent to receive text messages from Coastal Pediatric Group, including general and/or promotional messages. You may opt out of receiving general and/or promotional messages at any time by following the opt-out instructions provided in the messages. Your continued use of our services constitutes your ongoing consent to these terms.
No Mobile information will be shared with third parties or affiliates for marketing or promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared or sold to any third parties _____

I understand that Coastal Pediatric Group follows the CDC's recommendation of the childhood vaccines. To become established at Coastal Pediatric Group, I will provide my children's vaccination records and will sign the office policy that states if I do not follow the vaccine policy, my family will be dismissed from the practice. ___

We do not allow alternate or delayed vaccination schedule, and do not accept patients with religious exemptions. The flu vaccine, covid vaccine, meningitis vaccine, and the HPV vaccine are highly recommended, but not required.

PRIMARY INSURANCE

Name of Insurance _____Policy Holder Name _____ Policy Holder Sex _____ Policy Holder DOB_____ Member ID#_____

If you have **SECONDARY INSURANCE:**We will collect it in the office at check in. Please bring your ID and Insurance cards to the visit.

_____ _____
Patient or Guardian Signature Relationship to Patient Date