

Munir Loya, M.D.

Coastal Medical Group
150 East Medical Center Blvd, Suite D
Webster, TX 77598
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PATIENT INFORMATION

LAST NAME: _____ FIRST NAME _____ MID IN. ____ SEX: M ____ F ____

ADDRESS _____ CITY _____ ST: _____ ZIP: _____
(NO PO BOX PLEASE)

HOME PH#: () _____ - _____ CELL PH #: () _____ - _____ MARITAL STATUS _____

SOC. SEC.# _____ BIRTHDATE: _____ AGE: _____ DL# _____

EMAIL ADDRESS: _____ EMPLOYED BY: _____

EMPLOYER PHONE #: () _____ - _____ CONTACT PERSON: _____

EMPLOYER ADDRESS: _____ CITY _____ ST _____ ZIP _____

PRIMARY MEDICAL INS. CO: _____ POLICY # _____

ADDRESS: _____ GROUP # _____

SECONDARY INSURANCE _____ POLICY# _____

ADDRESS: _____ GROUP# _____

SPOUSE _____ GUARDIAN _____ NAME _____ SS# _____

BIRTHDATE: _____ PHONE#: _____ WORK#: _____

REFERRED BY: _____

NEXT OF KIN: _____ PHONE#: _____ WORK#: _____

IN CASE OF EMERGENCY NOTIFY: (OTHER THAN HOME AND BUSINESS)

1. _____ PHONE: _____ WORK: _____

2. _____ PHONE: _____ WORK: _____

AUTHORIZATION FOR MEDICAL CARE: I HEREBY REQUEST AND AUTHORIZE THE EXAMINATION AND TREATMENT OF THE ABOVE NAMED PATIENT. **RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE COMPANY BENEFITS:** I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF ANY INFORMATION AND FOR THE PAYMENT OF INSURANCE COMPANY BENEFITS TO COASTAL MEDICAL GROUP. IF THE INSURANCE COMPANY DENIES RESPONSIBILITY, I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME. I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____

INTERPRETER'S SIGNATURE: _____ DATE: _____