Coastal Podiatry, LLC
Rahn A. Ravenell, DPM Tamika MB. Ravenell, DPM

Patient Information:

Name:_____ SS #_____Date of Birth:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____
Marital Status: S M W Sep D Student? Yes No
Employer's Name:_____Work Phone:_____
Employer's Address:_____ City:_____State:_____Zip:_____
Race: American Indian or Alaska Native / Asian / Black / Hispanic / Native Hawaiian or Other Pacific Islander / White
Email: _____May we contact you via email (appointments/bills)? Y N

Emergency Contact:

Name:_____ Relationship: _____
Phone: _____ Cell: _____

Guarantor's Information (Must be completed if the patient is UNDER 18 years of age)

Name:_____ SS#:_____Date of Birth:_____
Address:_____City: _____State:_____ Zip:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Employer's Name:_____
Employer's
Address:_____City:_____State:_____Zip:_____

Insurance Information:

Primary Insurance_____Phone Number_____
Policy Holder's Name_____Policy Holder's Date of Birth_____
Policy Holder's Employer: _____
ID #_____ Policy #_____
Secondary Insurance_____Phone Number_____
Policy Holder's Name_____ Policy Holder's Date of Birth_____
Policy Holder's Employer: _____
ID #_____ Policy #_____

Co-pays, deductibles, and percentages which your insurance company does not pay will be collected at the time of your visit unless prior arrangements have been made with the office.

I hereby authorize Coastal Podiatry, LLC physicians and staff to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Coastal Podiatry, LLC. I authorize the release of medical records to the insurance company if records are requested to process my claims.

I certify that the information I have reported with regard to my insurance coverage is correct and current. I understand that the office of Coastal Podiatry, LLC will file my insurance for services received, but that I am responsible for the payment of these services should payment be denied for any reason.

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Patient / Guarantor Signature **Date**