



RICHARD C. HARTWELL, M.D., Ph.D. • JOHN SARRIS, M.D.
9 Hospital Drive, Toms River, New Jersey 08755

PATIENT INFORMATION SHEET

NAME OF PATIENT _____ AGE _____

ADDRESS _____
Street City State Zip Code

SOCIAL SECURITY # _____ DATE OF BIRTH _____

HOME PHONE (____) _____ CELL PHONE (____) _____

EMPLOYER _____ PHONE (____) _____

EMERGENCY CONTACT _____ PHONE (____) _____

REFERRING M.D. _____ ADDRESS _____

REASON FOR YOUR VISIT TODAY: _____

DO YOU SMOKE? NO ____ YES ____ PACKS PER DAY SMOKED: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST:

PLEASE CIRCLE YES OR NO:

- | | | |
|---|-----|----|
| ARE YOU ALLERGIC TO SHELLFISH OR IODINE DYE? | YES | NO |
| ARE YOU ALLERGIC TO LATEX? | YES | NO |
| DO YOU TAKE ASPIRIN OR VITAMIN E? | YES | NO |
| DO YOU TAKE ADVIL, MOTRIN, ALEVE OR NAPROSYN? | YES | NO |

LIST ALL MEDICATIONS AND DOSAGE: _____

LIST ALL HOSPITALIZATIONS AND SURGERIES WITH DATES: _____

PATIENT _____

DO YOU HAVE A LIVING WILL (ADVANCE DIRECTIVE)? YES _____ NO _____

PERSON IN CHARGE: _____ PHONE # _____

CHECK IF YOU HAVE HAD:

- ANGINA
- HEART ATTACK
- HEART MURMUR
- HYPERTENSION
- RHEUMATIC FEVER
- SHORTNESS OF BREATH
- EASY BRUISING OR BLEEDING
- A CORNEAL TRANSPLANT WHEN _____
- INJECTIONS OF SEX OR GROWTH HORMONES
- SEIZURES
- DIABETES
- HEPATITIS/AIDS/HIV
- KIDNEY DISEASE
- ULCER DISEASE
- LUNG DISEASE
- THYROID DISEASE

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME _____
 ID # _____ GROUP # _____
 ADDRESS _____

SECONDARY INSURANCE CO. NAME _____
 ID # _____ GROUP # _____
 ADDRESS _____

IS THIS WORK RELATED? _____ AUTO ACCIDENT? _____ OTHER ACCIDENT

I authorize all medical and/or surgical benefits, including Major Medical, Medicare, private insurance or health plans to COASTAL NEUROSURGERY. I am responsible for all charges incurred for my medical care. If Coastal Neurosurgery, P.A. is unable to collect the monies due us in a reasonable time, a finance charge of 1.5% per month will be added to your balance each month. If your account is sent to a collection agency, all collection costs and legal fees will be added to your account. I authorize the release of any medical information necessary to process my claim.

PLEASE SIGN _____ DATE _____

