Third Coast Family Practice
Craig Matheson, D.O.

Complete this form entirely to ensure correct billing

Name_____Gender: Male_____Female_____Transgender_____
DOB_____ SS#_____
Address_____City_____State_____Zip_____
Phone#_____ Cell Phone# _____Work#_____
Email Address: _____
Employer:_____Marital Status:_____
Preferred method of contact: □ home phone; □ cell phone; □ text message; □ patient portal
Emergency contact name_____relationship_____Phone#_____

What is the name of your primary insurance carrier?_____ Policy # _____
What is the name of the insured on the primary insurance carrier?
Insured's name_____DOB_____SS#_____

What is the name of your secondary insurance carrier?_____ Policy # _____
What is the name of the insured on the secondary insurance carrier?
Insured's name_____DOB_____SS#_____

Please provide a copy of your insurance card(s) and your driver's license to the receptionist.

Authorizations: For each question check Yes or No, then sign below

	Yes	No
• I have access to the Notice of Privacy Practice from Third Coast Family Practice (posted).	___	___
• I authorize Third Coast Family Practice to leave messages regarding appointments/results.	___	___
• I authorize the provider at Third Coast Family Practice to examine me and render medical treatment deemed necessary for evaluations, management and treatment of my medical conditions.	___	___
• I authorize the provider to submit claims to my insurance company and be paid for these services.	___	___
• I understand I am financially responsible according to the Payment Policy that I have read and signed.	___	___
• Our office subscribes to a pharmacy service that allows us to see what medications are covered by your insurance. In addition, this service gives us access to your prescription history. Do we have your permission to see this information?	___	___

- What is the name of your preferred Pharmacy? _____

- Are there persons with whom we can discuss medical information, test results, or appointment information? If yes, identify their names, birth date, and your relationship to him/her. Yes____ No____

Name_____DOB_____Relationship_____Phone Number_____

Name_____DOB_____Relationship_____Phone Number_____

Name_____DOB_____Relationship_____ Phone Number_____

Patient's signature:_____Date_____