Coastal Medical
Lifespan. Delivering health with care®

Contact Information Form

Patient Name: _____ DOB: _____ /_____ /_____

Emergency Contact Information

In the event that you are involved in an accident or other emergency, we urge you to complete all information below:

Primary Contact Person:

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ___ Yes ___ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact Person:

Name: _____ DOB: _____ / _____ / _____

Relationship to patient: _____

Are they a Coastal Medical Patient: ___ Yes ___ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to Discuss

I, the undersigned, hereby give Coastal Medical permission to discuss my medical information with:

Name #1: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name #2: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient/Legal Guardian Signature: _____

Date: _____ / _____ / _____