Coastal Thoracic Surgical Associates

Affiliated with New Hanover Regional Medical Center

Dr. Ivan David, M.D.
Dr. Peter Kane, M.D.
Dr. Howard F. Marks, Jr., M.D.

PATIENT REGISTRATION FORM - PART 1

Patient's Name _____

Address _____
Number Street City State Zip

Home Phone _____ Work _____ Cell _____

Date of Birth _____ Age _____

Social Security Number _____ Gender: ° M ° F

Marital Status ° Married ° Single ° Divorced ° Widowed ° Other

Employment ° Full ° Part ° Retired ° None

Relationship to the Insured ° Self ° Spouse ° Child ° Other

Place of Employment _____ Phone _____

Spouse's Name _____

Spouse's Date of Birth _____

Spouse's Place of Employment _____ Phone _____

Spouse's Social Security Number _____

Person Legally Responsible for Account _____

Relationship to Patient _____

Notify in Case of Emergency _____ Phone _____

Referring Doctor _____

Family Doctor _____

Cardiologist _____

Please print and complete this form. Bring it to your appointment or fax it to us at 910.251.3760.

Coastal Thoracic Surgical Associates

Affiliated with New Hanover Regional Medical Center

Dr. Ivan David, M.D.
Dr. Peter Kane, M.D.
Dr. Howard F. Marks, Jr., M.D.

PATIENT REGISTRATION FORM - PART 2

Patient's Name _____ Date of Birth _____

Describe your Current Problem and How it Occurred: _____

When Did this Problem Begin? _____

Were X-Rays Taken? ° Yes ° No

Did You Bring X-Rays Today? ° Yes ° No

Did You Have a Catheterization Performed? ° Yes ° No

If So, by Whom? _____

Did You Have an Echocardiogram Performed? ° Yes ° No

Have You Been Treated Previously by a Physician in this Practice? ° Yes ° No

If Yes, Approximate Date _____ and by Whom _____

Authorization For Treatment

I Hereby Authorize Treatment, _____
(Please print full name)

Patient's Signature Date

Patient's Representative's Signature (If patient is a minor or unable to sign)

Comments or Concerns _____

Please print and complete this form. Bring it to your appointment or fax it to us at 910.251.3760.