LITTLE RIVER HEALTHCARE

Patient Information

Name (Last, First, MI) _____Age: _____Drivers License _____

Address: _____City/State/Zip: _____

Home Phone #: _____Cell Phone#: _____Social Security #: _____

Date of Birth: _____Male ☐ Female ☐ Marital Status: _____

Advanced Directive: (check one) ☐ Yes ☐ No ☐ I would like information about advanced directives; Organ Donor: ☐ Yes ☐ No

Patient's Employer: _____ Occupation: _____

Address: _____City / State / Zip: _____

Work Phone #: _____ E-Mail Address: _____

Guarantor Information

Responsible Party: _____Social Security #: _____Relationship: _____

Address: _____City / State / Zip: _____

Home Phone#: _____Cell Phone#: _____Work Phone #: _____

Guarantor's Employer:_____ City State / Zip: _____

Emergency Contact Information

Nearest Relative: _____ Relationship:_____Social Security # _____

Address: _____City / State / Zip:_____

Home Phone #: _____Employer: _____

Employer's Address: _____City / State / Zip: _____Work Phone # _____

Notify in Case of Emergency: _____Relationship: _____

Address: _____City / State / Zip: _____Phone #: _____

Financial / Insurance Information

MUST PRESENT INSURANCE CARD/FORMS, DRIVERS LICENSE AND SOCIAL SECURITY CARD

METHOD OF PAYMENT: (Check one) ☐ Cash ☐ Worker's Comp ☐ Commercial Insurance ☐ Medicare ☐ Medicaid

Primary Insurance Carrier: _____ Type of insurance (circle one) HMO PPO POS Other

Policy Number:_____ Group Number or Name:_____ Effective Date:_____

Policy Holder Name: _____ Date of Birth:_____

Employer: _____ Policy Holder's Social Security Number:_____

Relationship to Patient: Self / Spouse / Parent / Other (please explain) _____

Medicare Lifetime Authorization: I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

_____ _____ _____

Patient Signature Medicare Number Date