Patient Demographics

LITTLE RIVER HEALTHCARE

Patient Information

Name (Last, First, MI) _____ Age: _____ Driver's License #: _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone #: _____ Social Security #: _____

Date of Birth: ____ / ____ / _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

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

Is this visit the result of an accident? ☐ Yes ☐ No ☐ Other: _____

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, DRIVER'S LICENSE AND SOCIAL SECURITY CARD

METHOD OF PAYMENT: ☐ Cash ☐ Worker's Comp ☐ Commercial Insurance ☐ Medicare ☐ Medicaid

Primary Insurance Carrier: _____ Type of Insurance: ☐ HMO ☐ PPO ☐ POS ☐ Other

Policy #: _____ Group Name/ Group #: _____ Effective Date: ____ / ____ / _____

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

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Patient Signature: _____ Date: _____ / _____ / _____