



Patient Information

Date ____/____/____
 Mr. Mrs. Ms. Dr. First Name _____ M.I. ____ Last Name _____
Sex : Male Female Birth Date ____/____/____ Age ____ Soc. Sec. # _____
Street _____ City _____ State ____ Zip _____
Home Tel. (____) _____ Cell.(____) _____ Have you ever been a patient of our hospital? Yes No
Driver's Lic. # _____ Employer _____
Bus.Tel.(____) _____ Occupation _____
Street _____ City _____ State ____ Zip _____

Responsible Party

Who will be responsible for you account? Self Spouse Father Mother Other _____
(If self, skip to the next section)
Name _____ S.S. # _____ Birth Date ____/____/____
First Name Last Name
Street _____ City _____ State ____ Zip _____
Tel.(____) _____ Employer _____ Bus Tel.(____) _____

Spouse or Other Guarantor Information (if different from above)

Name _____ S.S.# _____
First Name Last Name
Birth Date ____/____/____ Relationship _____
Street _____ City _____ State ____ Zip _____
Tel.(____) _____ Employer _____ Bus. Tel.(____) _____

Insurance Information

Student: Full Time Part Time Not **Marital Status:** Married Single Divorced Widowed Legally Separated
Employed: Full Time Part Time Retired Not **Do you belong to a PPO or HMO?** PPO HMO Neither

Primary Insurance Information

Ins. Co. Name _____ Tel.(____) _____
Address _____ City _____ State ____ Zip _____
Contract # _____ Group # _____ Group Name _____
Insured Party _____ Relationship to Insured _____
First Name Last Name
Address _____ City _____ State ____ Zip _____
Tel.(____) _____ S.S. # _____ Date of Birth ____/____/____ Sex: Male Female

Secondary Insurance Information

Ins. Co. Name _____ Tel.(_____)_____

Address _____ City _____ State _____ Zip _____

Contract # _____ Group # _____ Group Name _____

Insured Party _____ Relationship to Insured _____

Address _____ **First Name** _____ **Last Name** _____ State _____ Zip _____

Tel.(_____)_____ S.S. # _____ Date of Birth ____/____/____ Sex: Male Female

Tertiary Insurance Information

Ins. Co. Name _____ Tel.(_____)_____

Address _____ City _____ State _____ Zip _____

Contract # _____ Group # _____ Group Name _____

Insured Party _____ Relationship to Insured _____

Address _____ **First Name** _____ **Last Name** _____ State _____ Zip _____

Tel.(_____)_____ S.S. # _____ Date of Birth ____/____/____ Sex: Male Female

Workers' Compensation Information

Date of Injury ____/____/____ Body Part Injured _____ Date off Work ____/____/____

Employer at the time of injury _____ Employer Tel.(_____)_____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Ins. Co. Tel.(_____)_____

Address _____ City _____ State _____ Zip _____

Claim # _____ Adjuster /Case Manager Name _____

Automobile Injury Information

Date of Injury ____/____/____ Body Part Injured _____ City & State Injury Occurred _____

Insurance Company _____ Ins. Co. Tel.(_____)_____

Address _____ City _____ State _____ Zip _____

Claim # _____ Adjuster/Case Manager Name _____

Policy Holder Name _____ Tel.(_____)_____

First Name _____ **Last Name** _____

Do you have coordination of benefits with you primary health care insurance? Yes No



ASSIGNMENT OF MEDICAL BENEFITS OTHER THAN MEDICARE

I hereby assign, transfer, and set over to Oakland Regional Hospital all of my rights, title and interest to my medical reimbursement benefits under my insurance policy or Workers' Compensation carrier for any services furnished me by them, Oakland Regional Hospital.

I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ Date ____/____/_____
Signature of Patient or Authorized Representative

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare Benefits be made on my behalf to Oakland Regional Hospital for any services furnished to my by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ Date ____/____/_____
Signature of Patient or Authorized Representative

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Oakland Regional Hospital, its physicians and staff, are authorized to share information and provide copies of my entire medical records, including all written reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, and attendance compliance with respect to all care or treatment, to my insurance companies, doctors, treating facilities, and my employer in the case of Workers' Compensation.

_____ Date ____/____/_____
Signature of Patient or Authorized Representative