ISLAND HOSPITAL

PATIENT INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Race	Religion	E-mail Address
Daytime Phone	Marital Status	DOB	Social Security #	Gender
Mother's Name (If patient is a minor)	Father's Name (If patient is a minor)		

GUARANTOR	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Relationship to Patient	DOB	Social Security #	Gender
Employer			
Employer's Address	City	State	Zip
Employer's Telephone Ext.	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown		

PATIENT EMPLOYMENT	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown		
Occupation	Employer		
Address	City	State	Zip
Employer's Telephone Ext.	Employer's Telephone Ext.		

PRIMARY INSURANCE	Primary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

SECONDARY INSURANCE	Secondary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

ISLAND HOSPITAL

NEXT OF KIN INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

PERSON TO NOTIFY	Last Name	First Name	Middle Initial
Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed or prescribed by the health care provider during clinic visits.

______________________________ ______________________

Signature *Date/Time*

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

______________________________ ______________________

Signature *Date/Time*

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

______________________________ ______________________

Signature *Date/Time*

MEDICARE PATIENTS:
STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

______________________________ ______________________

Signature *Date/Time*

Originator/Author: Codd, Patty Director Family Care & Specialty Clinics
Original: 01/08/2018; Approved: 01/08/2018; Reviewed: 01/08/2018
Printed copies are for reference only. Please refer to the electronic copy for the latest version