

LAST MENSTRUAL PERIOD				EXPT. DUE DATE			
PHYSICIAN / OBSTETRICIAN			PEDIATRICIAN			PRIMARY CARE PHYSICIAN	
PATIENT NAME (Please Print)		LAST	FIRST	MIDDLE INITIAL	MAIDEN OR PREVIOUS NAME(S)		
PATIENT ADDRESS		STREET (APT#)	CITY	STATE	ZIP	PHONE (Area Code)	
MARITAL STATUS: (Circle One) SIN MAR DIV WID SEP		RELIGION		BIRTHDATE	MO	DAY	YR
EMPLOYER		EMPLOYER ADDRESS			PATIENT'S OCCUPATION		
CITY		STATE		ZIP		PHONE	

**Spouse / Significant Other Information**

NAME OF SPOUSE / SIGNIFICANT OTHER				SPOUSE BIRTHDATE				MO	DAY	YR
SPOUSE EMPLOYER					EMPLOYER ADDRESS					
CITY			STATE		ZIP		PHONE		SOC. SEC # OF SPOUSE	

**Alternate Emergency Contact**

NAME			RELATION TO PATIENT			WORK PHONE		HOME PHONE		
ADDRESS				CITY		STATE		ZIP		

THE FOLLOWING SECTIONS APPLY TO THE FINANCIAL RESPONSIBILITY FOR THIS HOSPITAL STAY.  
SECTION 1. IN ORDER TO BILL YOUR INSURANCE COMPANY (CARRIER), WE WILL NEED THE FOLLOWING INFORMATION:

<b>PRIMARY INSURANCE</b>		<input type="checkbox"/> HMO	<input type="checkbox"/> Out of State / Area	<b>SECONDARY INSURANCE</b>		<input type="checkbox"/> HMO	<input type="checkbox"/> Out of State / Area
		<input type="checkbox"/> PPO	<input type="checkbox"/> _____			<input type="checkbox"/> PPO	<input type="checkbox"/> _____
1) Subscriber Name		1) Subscriber Name		2) Subscriber SS#		2) Subscriber SS#	
2) Subscriber SS#		3) Subscriber D.O.B.		3) Subscriber D.O.B.		4) ID/Policy #	
3) Subscriber D.O.B.		4) ID/Policy #		4) ID/Policy #		5) Relationship to Patient	
4) ID/Policy #		5) Relationship to Patient		5) Relationship to Patient		6) Name of Insurance Co	
5) Relationship to Patient		6) Name of Insurance Co		6) Name of Insurance Co		7) Address	
6) Name of Insurance Co		7) Address		7) Address		8) City, State, Zip	
7) Address		8) City, State, Zip		8) City, State, Zip		9) Name of Medical Group	
8) City, State, Zip		9) Name of Medical Group		9) Name of Medical Group		10) Group Name	
9) Name of Medical Group		10) Group Name		10) Group Name		11) Group #	
10) Group Name		11) Group #		11) Group #		12) Union Local	
11) Group #		12) Union Local		12) Union Local		13) Ins. Phone#	
12) Union Local		13) Ins. Phone#		13) Ins. Phone#			
13) Ins. Phone#							

RELEASE OF DIAGNOSIS: I here by authorize The Good Samaritan Hospital to release my diagnosis to my insurance carriers and/or employer for the purpose of insurance verification.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT \_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to The Good Samaritan Hospital, the hospital benefits otherwise payable to me for the hospitalization of this patient. I understand that I am financially responsible to the hospital for the charges not covered by my group insurance plan.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_ (NAME OF PERSON INSURED)

SAME AS 1