

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)		RELIGION		BIRTHDATE MO DAY YR		SOC. SEC.#	
MARITAL STATUS: (Circle One) SIN MAR DIV WID SEP		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:

PRIMARY INSURANCE		<input type="checkbox"/> HMO	<input type="checkbox"/> Out of State / Area	SECONDARY INSURANCE		<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)