

Confidential Patient Information

Patient Information		Today's	Date:
Last Name	First	Middle	Social Security Number
Date of Birth (MM/DD/CCYY)		Gender	
		☐ Male	☐ Female
Address		City	State Zip Code
Home Telephone Number () Marital Status		Cell Phone Number	
☐ Single ☐ Married Race: ☐ White ☐ Asian ☐ A	☐ Separated	☐ Divorced ☐ ☐ American Indian A	Widow laskan Native □ Other
Ethnicity:	□ Non-Hispan	ic	
Does patient Smoke? □ Yes	□ No		
Does patient have a Living Will or	r an Advanced Direct	ive?	No 🗆 Unknown
Has patient signed a HMC HIPAA	(Privacy) Acknowle	edgement/Consent Form	a? □ Yes □ No □ Unknow
Does the patient have Medicare?	☐ Yes ☐ No If	Yes, answer following	questions:
1. Patient's Retirement Date_	(mm/dd/ccyy)	Spouse's Retirem	ent Date
2. Is today's visit related to an	y Work Related injur	ry or injury caused by ar	nother? \square Yes \square No
If Yes , please provide: Dat and Person Responsible	e of injury	yy) Location (e.g. hon	ne, farm, work, etc.)
Have you had any prior hospitaliz	ations in the last 60 d	lays? 🗆 Yes 🗆 No	If Yes, answer following ques
1. Date of Hospitalization_			
2. Place of Hospitalization_			
Does patient have a Primary	or Family Physicia		
Last Name		First Name	
Address	City	1	State

Employer Address City State Zip Code Occupation Work Number () Guarantor Information (Person Responsible for Patient's Bill) Patient's Relationship to Guarantor Self Spouse Child Other Last Name First Middle Social Security Number Gender Male Female Address City State Zip Code Home Telephone Number () Guarantor Employment Information Guarantor Employer Employer Address City State Zip Code City State Zip Code Work Phone Number () Emergency Contact Information Last Name First Middle Relationship to Patient	withtolineur intolinisiton				
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Home Telephone Number Work or Cell Phone Number					
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Please provide a copy of your Insurance Information for billing purposes. If you do not have the insurance card with you, please bring of fax it (both front and back) to Admitting Office ASAP. Otherwise, the account will be set up as Private Pay and your insurance will not be billed by us. Thank You!

Admitting Office Fax number is (309) 449-4679.

If you do not have insurance, Medicare, or Public Aid, HMC has a Financial Assistance Program available for those who are unable to pay all or any part of their bills. Please call (309) 449-4380 for more information.