Hopedale Medical Complex

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 ( )	Cell Phone Number ( )

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Race:

☐ White ☐ Asian ☐ African American ☐ American Indian Alaskan Native ☐ Other

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

Does patient Smoke? ☐ Yes ☐ No

Does patient have a Living Will or an Advanced Directive? ☐ Yes ☐ No ☐ Unknown

Has patient signed a HMC HIPAA (Privacy) Acknowledgement/Consent Form? ☐ Yes ☐ No ☐ Unknown

Does the patient have Medicare? ☐ Yes ☐ No If **Yes**, answer following questions:

1. Patient's Retirement Date_____ (mm/dd/ccyy) Spouse's Retirement Date_____ (mm/dd/ccyy)
2. Is today's visit related to any Work Related injury or injury caused by another? ☐ Yes ☐ No

   If **Yes,** please provide: Date of injury _____ (mm/dd/ccyy) Location_____ (e.g. home, farm, work, etc.)

   and Person Responsible_____

Have you had any prior hospitalizations in the last 60 days? ☐ Yes ☐ No If **Yes**, answer following questions:

1. Date of Hospitalization_____
2. Place of Hospitalization_____

Does patient have a Primary or Family Physician?

Last Name	First Name	

Address	City	State

Employment Information

Patient Employer			
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 - -
Date of Birth (MM/DD/CCYY)	Gender ☐ Male ☐ Female		
Address	City	State	Zip Code
Home Telephone Number ( )	Cell Phone Number ( )		

Guarantor Employment Information

Guarantor Employer			
Employer Address	City	State	Zip Code
Occupation	Work Phone Number ( )		

Emergency Contact Information

Last Name	First	Middle	Relationship to Patient
Address	City	State	Zip Code
Home Telephone Number ( )	Work or Cell Phone Number ( )		

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.