THANK YOU FOR CHOOSING MIAMI COUNTY MEDICAL CENTER

Section I: Patient Information

Legal Name: (last)____________________ (first)_____________________ (mi)________Date of Birth:_______________
Address: ____City:______________State:____Zip:__________
Home Phone #: __________________________ Cell Phone #_____________________SS#:__________________________
Sex:___ Marital Status: Minor__ Single__ Married__ Widowed__ Separated__ Divorced__
Family Physician (first and last name): ____
Employer name, address, and phone:____
____

Please choose the race with which you most closely identify (circle one): white black or African American Asian American Indian or Alaska Native Native Hawaiian or other Pacific Islander Decline
Please indicate Hispanic or Latino Origin (ethnicity) (circle one) Hispanic or Latino Not Hispanic or Non-Latino Decline
What is your preferred language? (circle one) English Other ____ Decline
Would you like a religious preference listed on your file? None___ or________________________________(please specify)

Section II: Responsible Party (if different from above)

Relationship to Patient: Spouse__ Parent__ Other _____________(please specify)
Name: (last)__________________________ (first)_________________ (mi)______ Date of Birth: _____________________
Address: ____City:______________State:____Zip:_________
Home Phone #:________________________ Cell Phone # _____________________SS #:___________________________
Sex:___ Marital Status: Minor__ Single__ Married__ Widowed__ Separated__ Divorced__
Employer Name, address, and phone: ____
____

If you have insurance who is the policyholder: Self ___ Spouse ___ Mother ___ Father___ or other________________

Section III: Medicare Questions (complete if you have medicare)

Are you eligible for Medicare due to: (circle one) Age Disability End Stage Renal
Is your visit today related to Black Lung Disease? Y N
Is your visit today authorized by the VA? Y N
Is your visit today covered under a government grant or research program? Y N
Are you or a spouse currently employed? Y N
If you are retired please provide the last day you worked ____
If you are married and your spouse is retired, please provide the last day your spouse worked ________________________
Do you have Group Health Plan coverage based on your own or a spouse's current employment? Y N
If you answered YES, does that employer sponsor more than 100 employees? Y N

Section IV: Accident/Injury Information

Is your visit today a result of an accident or injury? Y or N
Date/time of accident/injury_________________________ City/state of accident/injury_________________________
Was your injury a result of a motor accident? Y or N If motor vehicle accident, was a police report made? Y or N
Name of Law Enforcement Department____
Location of accident/injury (circle one) HOME or OTHER
If OTHER, please provide location details of your accident/injury____
____
Description of accident/injury____
____

Section V: Emergency Contact Information

Name __________________________________ Date of Birth______________ Relationship________________
Home Phone # ______________________________Cell Phone# ___________________________
Address____
Employer name and address____

Name __________________________________ Date of Birth______________ Relationship________________
Home Phone # ______________________________Cell Phone# ___________________________
Address____
Employer name and address____

For Internal Use Only: Date:_______________ Time:__________ Financial Number:____________________________
Copy of Photo ID Y or N Copy of Insurance Card or other liability payer Y or N