Catahoula Parish Hospital District #2

Patient Information

Patient's Name:_____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____ Race: _____

Mailing Address: _____

☐ Check box if mailing and physical are the same.

_____

Physical Address: _____

_____

Telephone Number: _____-_____-_____(home) _____-_____-_____ (cell)

_____-_____-_____ (work)

Marital Status (Circle One): Single Married Separated Divorced Widowed

Social Security Number: _____-_____-_____ Driver License Number:_____

Responsible Party

Responsible Party's Name: _____ Phone: _____-_____-_____

Mailing Address: _____

Responsible Party's Employment: _____

Insurance

Insurance Company: _____

Mailing Address: _____

Policy Holder's Name: _____ Date of Birth: ___/___/_____

Policy Number: _____

Policy Holder's Employment: _____

(We will be happy to make a copy of your insurance card & file for your reimbursement.)

Relative (Not living with patient)

Nearest Relative: _____ Relationship: _____

Phone: _____-_____-_____ Mailing Address: _____

I authorize the release of any medical information necessary to process the claim and request payment of Medicare benefits. I acknowledge full responsibility for the services rendered. I understand that all fees may not be covered in full by my insurance company. Therefore, the patient or the responsible party is completely responsible for the payment of all services not covered by insurance.

Signature: _____ Today's Date: _____/_____/_____