ER PATIENT INFORMATION SHEET

Ortonville Area Health Services

Date: _____

Insurance Card Copied (Please Attach) Yes ☐ No ☐
Work Related Yes ☐ No ☐
Other Accident Yes ☐ No ☐
Driver License Yes ☐ No ☐

Internal Use Only

Place Patient Label Here

Registered in One Chart Yes No

PATIENT NAME: _____ ☐ FEMALE ☐ MALE
(LEGAL) LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET PO BOX CITY STATE ZIP

HOME PHONE: ( )_____ CELL PHONE: _____ E-MAIL: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

BIRTH DATE: _____ AGE:_____ SOC SEC NO: _____

EMPLOYER:_____OCCUPATION:_____WORK PHONE: ( )_____EXT: _____

PATIENT'S ALTERNATE NAME (NICK NAMES/MAIDEN NAMES): _____

SPOUSE'S NAME: _____BIRTH DATE:_____SOC SEC NO:_____

EMPLOYER: _____ OCCUPATION:_____ WORK PHONE: _____EXT: _____

IF PATIENT IS A MINOR

RESPONSIBLE PARTY / BILLING INFORMATION:

MOTHER'S NAME: _____ BIRTH DATE: _____ SOC SEC NO:_____

ADDRESS: _____HOME PHONE: ( ) _____
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: _____WORK PHONE: (_____) _____CELL PHONE:_____

FATHER'S NAME:_____ BIRTH DATE: _____ SOC SEC NO:_____

ADDRESS: _____HOME PHONE: ( ) _____
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: _____ OCCUPATION:_____

WORK PHONE: (_____) _____ CELL PHONE: _____

INSURANCE GUARANTOR'S INFORMATION - If patient under age of 18 - fill out with parent/guardian information
NAME:_____ BIRTH DATE: _____ SOC SEC NO:_____

ADDRESS: _____HOME PHONE: ( ) _____
STREET PO BOX CITY/STATE/ZIP

EMERGENCY CONTACT:

NAME: _____RELATIONSHIP TO PATIENT: _____

ADDRESS: _____
STREET PO BOX CITY STATE ZIP

HOME PHONE: (_____) _____CELL PHONE:_____

EMPLOYER: _____ WORK PHONE: (_____) _____ EXT. _____

Verified By: _____ Date: _____