CANNON MEMORIAL HOSPITAL

PATIENT INFORMATION
Cannon Physician Practices

PATIENT INFORMATION

Full Name:				Name you wish to be called:	
Social Security #:			Date of Birth:		
Mailing Address:				Zip Code:	
Home Phone #:			Cell Phone #:		
Email Address:			I prefer to be notified by: (Circle One)		Mail Phone Email
Age:	**Gender:**	**Race:**	**Language Preference:**	English Spanish Other (Please Specify)	
Ethnicity: (circle one)	Hispanic/Latino Not Hispanic/Latino		Marital Status:	S M W D SEP	
Employment Status:	Full Time Part Time Self Retired None		Student Status:	Full Time Part Time None	
Employer/School Name:			Work Phone #:		
Employer Address:					
Family Physician's Name:			Referring Physician's Name: (if applicable)		
Emergency Contact Name & Phone #:					
Do you have Advanced Directives? YES NO If yes check type Health Care Power of Attorney/Living Will ___ DNR___					
If patient is a MINOR list parent/guardian name and phone #: _____ Social Security #: _____ Date of Birth: _____					

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber (Legal Name):			
Telephone:			
Relation to patient:			
Date of Birth:			
Social Security #:			
Employer:			
Employer Address:			
City, State:			
Zip Code:			
Employer Phone:			
Insurance Company:			
Subscriber ID #:			
Group #:			
Patient ID (if different):			
Insurance Phone #:			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment as ordered by a physician and certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Cannon Memorial Hospital. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

Signature:_____ **Date:** _____