

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
          First                          Middle                          Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Status: Married Single Divorced Student Widow Other: \_\_\_\_\_

Occupation/Major: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer/Institution: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Employer's/ Institution Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Full or Part Time

Name of Spouse: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation/Major: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer/Institution: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Employer/Institution Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Full or Part Time

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible.*

Responsible Party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation/Major: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer/Institution: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Employer/Institution Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*By signing below, I verify the Patient Demographic information on this page is accurate and acknowledge that I have reviewed, understand and freely agree to the statements below.*

I consent to such diagnostic therapeutic procedures and physician care with the acknowledgement that no guarantees have been made to me as a result of treatments of examinations.

I give permission to Community Memorial Hospital d/b/a Syracuse Medical Center and d/b/a Weeping Water Medical Center to file my claims with my insurance and also for my consent for the release of any medical information necessary to process my claims. I hereby authorize payment of medical benefits directly to Community Memorial Hospital d/b/a Syracuse Medical Center and d/b/a Weeping Water Medical Center.

I understand that I am financially responsible for the fees that Medicare, insurance or other third party payers do not cover for services provided.

I understand that Syracuse Medical Center and Weeping Water Medical Center is not responsible for my personal valuables. This form has been fully explained to me and I certify that I understand its contents.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_