



Wheaton Franciscan Healthcare

Patient Information

- Covenant Clinic Site _____
- Covenant Medical Center
- Mercy Hospital
- Sartori Memorial Hospital

Today's Date _____

Patient's Name _____
First Middle Last Maiden

Marital Status: Married Single Divorced Widowed Other Race: _____

Birth Date: _____ Social Security # _____ Sex: M F

Address _____
Street City State Zip Code

Home Phone _____ Work Phone _____
Area Code Area Code

Church Preference _____

Patient's Employer Information

Name of Employer _____ Status: Full-Time Part Time
Occupation _____ Date of Employment _____

Spouse Information

Name _____ Date of Birth _____
Social Security # _____ Telephone _____
Address _____
Street City State Zip Code

If patient is under the age of 18 please complete

Father's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____
Mother's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____

Nearest Relative or Person to Notify in Case of an Emergency

Name _____ Phone _____
Address _____

To hospital in last 2 months? Hospital _____ *Dates of Stay*

Attending Physician _____ Is this due to an accident? Yes No

Admitting Physician _____ Auto Work Home Other _____

Referring Physician _____ Date & Time of Accident _____

Primary Care Physician _____ Where Occurred _____

Insurance Form

Patient's Name _____ DOB _____

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* _____

Primary Insurance

Name of Insurance Company _____

Effective Date _____ Primary Care Physician _____

Policy # _____ Group # _____ Pre-certification? Procedure Hospitalization

Policy Holder's Name _____ MALE / FEMALE

Address _____ Phone # _____

Birth Date City _____ State _____ Zip _____ Social Security # _____

Policy Holder's Employer _____ Hire Date _____ Status PT FT

Address _____ Phone # _____

City _____ State _____ Zip _____

Please List Dependents Under this Coverage – Name, Date of Birth, Primary Care Physician

Patient's Name _____

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* _____

Secondary Insurance

Name of Insurance Company _____

Effective Date _____ Primary Care Physician _____

Policy # _____ Group # _____ Pre-certification? Procedure Hospitalization

Policy Holder's Name _____ MALE / FEMALE

Address _____ Phone # _____

Birth Date City _____ State _____ Zip _____ Social Security # _____

Policy Holder's Employer _____ Hire Date _____ Status PT FT

Address _____ Phone # _____

City _____ State _____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS: I hereby authorize insurance and/or Medicare payments for services rendered to me, or my dependents, to be paid to Covenant Clinic. I hereby agree to pay Covenant Clinic any and all charges that exceed or that are not covered by my health insurance coverage. I also authorize Covenant Clinic to release all medical information necessary to process my claims.

Signed _____ Dated _____