

Bloomington Meadows Hospital - Client Information Form

If you need assistance filling out the form, please ask!

Today's Date _____

Patient Name: _____ Male _____ Female

Street Address _____

City _____ State _____ Zip _____

Home Phone # () _____ - _____ Date of Birth _____ Age _____

Race: White _____ Black _____ Hispanic _____ Asian _____ Indian _____ Multiracial _____ Other _____

Patient's Social Security # _____ - _____ - _____ Marital Status ___S___M___D___W

Family Doctor _____ Doctor's Phone # () _____ - _____

ADULTS, please complete spouses section below:

CHILDREN & ADOLESCENTS, please complete ALL sections below:

Parental/ Spouses Information

Spouse's Name _____

OR

Mother's Name _____

Father's Name _____

Address _____

Address _____

City _____ State _____

City _____ State _____

Zip _____ Phone # () _____ - _____

Zip _____ Phone # () _____ - _____

Age _____ Birth date _____

Age _____ Birth date _____

Social Security # _____ - _____ - _____

Social Security # _____ - _____ - _____

Marital Status ___S___M___D___W

Marital Status ___S___M___D___W

Occupation _____

Occupation _____

Employer _____

Employer _____

Work Address _____

Work Address _____

City _____

City _____

State _____ Zip _____

State _____ Zip _____

Work Phone # () _____ - _____

Work Phone # () _____ - _____

Who is the Patient's Legal Guardian

Both Mother and Father Mother Only Father Only

Other:

Legal Guardian: _____ Relationship to Patient: _____

Address: _____ City _____ State _____ Zip _____

Home Phone# () _____ - _____ Work Phone# () _____ - _____

Social Security # _____ - _____ - _____ Age _____ Birth Date _____

Occupation _____ Employer _____

Work Address _____ City _____ State _____ Zip _____

If Ward of the County, Name of the caseworker/ Probation Officer: _____

Emergency Contact: Please list a person ***NOT living in the same household***

Name _____ Relationship to patient _____

Address _____ City _____ St _____ Zip _____

Home Phone # () _____ - _____ Work Phone # () _____ - _____

PLEASE COMPLETE THE BACK OF THE FORM

Bloomington Meadows Hospital - Client Information Form

Patient's School and/or Patient's Employer

Name of the School/Employer _____ Current Grade _____
Address _____ City _____ St _____ Zip _____

Insurance Information:

Medicaid coverage: ___ Yes ___ No Hoosier Healthwise/Medicaid # _____

If Yes, Do you have the Medicaid card with you: ___ Yes ___ No

Primary Insurance _____ Phone # () _____ - _____

Name of the Insured _____ Insured's Date of Birth _____

ID # _____ Insured's Relationship to Patient _____

Plan # _____ Insured's Employer _____

Do you have the insurance card with you: ___ Yes ___ No

Secondary Insurance _____ Phone # () _____ - _____

Name of the Insured _____ Insured's Date of Birth _____

ID # _____ Insured's Relationship to Patient _____

Plan # _____ Insured's Employer _____

Do you have the insurance card with you: ___ Yes ___ No

Consent for Assessment and/or Emergency Treatment

1. I, the undersigned, do hereby authorize the staff of Meadows Hospital to render assessment and/or medical screening.
2. I understand that I have the right to refuse any such assessment and/or medical screening.
3. I understand that all information is confidential unless an "Authorization to Release Information" has been signed.
4. I certify that I have read and fully understand the above consent for assessment and/or medical screening and I agree to absolve Meadows Hospital and its staff rendering the treatment(s) from any liability.

- I consent to the assessment and medical screen
- I acknowledge that I have received a copy of the Privacy Practices.

- I refuse the assessment and medical screen.
- I did not receive a copy of the Privacy Practices
Reason: _____

Individual Consenting or Refusing the
Assessment or Medical Screening

Date

Witness/Staff

Date

Parent/Legal Guardian

Date
