

**UNIVERSITY MEDICAL CENTER**  
**2390 WEST CONGRESS LAFAYETTE, LA 70506**

Pt Name: \_\_\_\_\_  
MR#: \_\_\_\_\_ Nur Sta: \_\_\_\_\_ Hosp Svc: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Pt#: \_\_\_\_\_ Room/Bed: \_\_\_\_\_ Pt Type: \_\_\_\_\_ Pt Sts: \_\_\_\_\_ FC: \_\_\_\_\_

**PATIENT INFO:**

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Mar Sts: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Phone Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**GAURANTOR INFO:**

Name: \_\_\_\_\_  
Pt Rel: \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Phone Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

**PRIMARY EMERGENCY CONTACT:**

Name: \_\_\_\_\_ PT Rel: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Phone Home: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**INSURANCE INFO:**

| InsCode | Ins Description | Policy # |
|---------|-----------------|----------|
| _____   | _____           | _____    |
| _____   | _____           | _____    |
| _____   | _____           | _____    |

Admit Date/Time: \_\_\_\_\_ Admitted By: \_\_\_\_\_ Adm Source: \_\_\_\_\_  
Admitting Doctor: \_\_\_\_\_  
Attending Doctor: \_\_\_\_\_  
Complaint: \_\_\_\_\_

Privacy Notice: \_\_\_\_\_ Informed of Adv Dir: \_\_\_\_\_ Adv Dir on File: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Do you need an interpreter? \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Comments: \_\_\_\_\_

**FREE CARE DETERMINATION APPLICATION INFO:**

Guar Monthly Inc: \_\_\_\_\_ Liquid Assets: \_\_\_\_\_ # in Family Unit: \_\_\_\_\_  
12 Mo Med Bill: \_\_\_\_\_ # of Dependent Children: \_\_\_\_\_

**SECOND EMPLOYMENT INFO:** Monthly Income: \_\_\_\_\_ Relation to Pt: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**ADDITIONAL FAMILY MONTHLY INCOME**

Social Sec: \_\_\_\_\_ Welfare \_\_\_\_\_ VA: \_\_\_\_\_ Pension: \_\_\_\_\_ Other: \_\_\_\_\_

Total Income: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_