Bloomington Meadows Hospital - Client Information Form

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

Today's Date _____

Patient Name: _____ (middle Initial) __Male ___Female
Street Address _____
City _____ State _____ Zip _____
Home Phone # ( ) _____ - _____ Date of Birth _____ Age _____
Race: White_____ Black____ Asian____ Am Indian ____Pacific Islander ____Unknown_____
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 _____
Address _____
City _____ State _____
Zip _____ Phone # ( ) _____ - _____
Age _____ Birth date _____
Social Security # _____- _____- _____
Marital Status ___S___M___D___W
Occupation _____
Employer _____
Work Address _____
City _____
State _____ Zip_____
Work Phone # ( ) _____ - _____

Father's Name_____
Address _____
City _____ State_____
Zip _____ Phone # ( ) ____ - _____
Age _____ Birth date _____
Social Security # _____-_____-_____
Marital Status ___S___M___D___W
Occupation _____
Employer _____
Work Address _____
City _____
State _____ Zip _____
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

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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
