CEDAR CREEK HOSPITAL of Michigan

DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT INFORMATION (PLEASE PRINT)**:**

Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Gender:_____ Marital Status: _____ Race: _____ Social Security #: _____

Pharmacy Name and Number:_____

RESPONSIBLE PARTY (if patient is a minor or has a guardian)**: Marital Status** ☐ **M** ☐ **S** ☐ **W** ☐ **D** ☐ Adult : Self-Responsible
Guarantor ☐ **Yes** ☐ **No**

Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Relationship to Patient: _____ Social Security #:_____

Phone – Primary #: _____ Seconday #: _____

INSURANCE INFORMATION: ☐ **Consent to speak to policy holder regarding benefit and financial information** ☐ **See copy of card(s)**

PRIMARY INSURANCE CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

SECONDARY INS. CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

PRESCRIPTION COVERAGE: _____ ID#: _____

Emergency Contact : _____ Relation To Patient: _____

Phone: _____ Alt Phone: _____

I hereby authorize Cedar Creek Hospital to communicate with my insurance company in order to verify benefits, obtain authorizations and all correspondence related to the submission and payment of my claims.

Signature: _____ Date: _____ Time:_____

Staff Signature: _____ Date: _____ Time:_____