Morton Rural Health Clinic
(806) 266-5566

Patient Information Form

Cochran Memorial Hospital and Clinic
EST. 1947

Please print clearly. Use only black or blue ink

Name		DOB	Sex
Race	Ethnicity		Language
Driver's License		SSN	
Home Phone		Cell Phone	
Address			
City	State		Zip Code
Employer			Work Phone
Marital Status	Spouse's Name		Spouse's Phone
Dependent?	If yes, Guardian's name		

INSURANCE

Important: we need whosever's name is on the insurance card's date of birth (DOB) in order to bill correctly. i.e. if mom's name is on the insurance card, we need mom's DOB. We also need to obtain a copy of your insurance card at every visit; **you must bring your insurance card with you to each visit**. If you do not bring your card at the time of your visit, you may be responsible for the charges!

Primary Insurance		
Insured Party's Name		Relationship
Insured Party's DOB	Policy No.	Group No.
Secondary Insurance		
Insured Party's Name		Relationship
Insured Party's DOB	Policy No.	Group No.

EMERGENCY CONTACT

Emergency Contact	
Relationship	Phone
Emergency Contact	
Relationship	Phone

I verify that the above information is factual and true to the best of my knowledge. I authorize the provider to employ x-ray, photographs, anesthetics, medications, surgeries and other equipment or aids as they deem necessary in order to provide the proper patient care.

I understand that payment, proof of insurance, and all co-pays are due **at the time of service**. I understand that if I cannot provide these, I may receive a statement or be asked to reschedule.

By signing below, I understand and agree to the above.

_____ _____

Print Name of Patient or Legally Authorized Representative | Relationship to patient

_____ _____

Signature of Patient or Legally Authorized Representative | Date