10233 W. Greenfield Av, West Allis, WI 53214
414-727-5750 Fax 414-727-5770

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient #	Admission Date	Room/Bed	Discharge Date	Length of Stay	Facility Name	Fac #

Patient Name (Last) (First) (MI)	Birth Date	Race	Sex	Maiden Name

Patient Address	City	State	Zip	Telephone

Patient SS #	Employer	Occupation	Employer Telephone

PERSON RESPONSIBLE FOR PAYMENT OF BILLS

Guarantor Name (Last) (First) (MI)		Guarantor Address	
Guarantor Telephone	Relationship to Patient	Emergency Notification (Name)	Telephone #
Guarantor Employer		Guarantor Employer Address	Telephone #

DRUG CARD INSURANCE INFORMATION
(PLEASE INCLUDE COPIES OF ALL INSURANCE CARDS)

Company Name	Address	Telephone

Insured's Name	Sex	PatRel	Policy Number	Group Name	Group Number

Other Insurance/Medicare	Address	Telephone

Insured's Name	Sex	PatRel	Policy/Medicare#	Group Name	Group Number

Other Insurance/Medicaid	Address	Telephone

Insured's Name	Sex	PatRel	Policy/Medicaid#	Group Name	Group Number

MD INFORMATION

Admitting Physician	Attending Physician	Other Physician

DIAGNOSIS & ALLERGIES

RESPONSIBLE PARTY AGREEMENT

AS RESPONSIBLE PARTY, I AGREE TO PAY FOR CHARGES THAT ARE NOT COVERED BY INSURANCE, OR OTHER THIRD PARTIES, INCLUDING CO-PAYS, CO-INSURANCE, DEDUCTIBLES, AND OVER THE COUNTER ITEMS

SIGNED ______________________ DATED ______________________

THE INFORMATION CONTAINED ON THIS FORM IS CONFIDENTIAL INFORMATION INTENDED FOR PRESCRIPTIONS PLUS TO USE IN ORDER TO FACILITATE PROVIDING PHARMACY SERVICES TO THE NAMED IINDIVIDUAL.