treasure valley hospital

PATIENT INFORMATION

Legal Name: (Last) (First) (Middle)

Mailing Address: (Street / PO Box) | **Home Phone:** Include Area Code

City: | **State:** | **Zip Code:** | **County:** | **Cell Phone:** Include Area Code

Date of Birth: dd/mm/yyyy | **Age:** | **Sex:** ◯M ◯F | **Marital Status:** (Circle One) ◯Single ◯Married Widowed◯ ◯Separated ◯Divorced

Social Security Number: | **Race: (Circle one)** Select one from below: | **Ethnicity: (Circle One)** Select one from below

Language:

Religion:

Check one if appropriate: ☐Patient is a minor, not employed ☐Patient is disabled, not employed ☐Patient is a full-time student, not employed

Patient's Employer | **Patient's Occupation**

Work Phone: | **Preferred Email:**

GUARANTOR INFORMATION (Responsible Party for Minors 17 and Under)

Relationship to Patient: ◯Father ◯Mother ◯Step-parent ◯Spouse ◯Life Partner ◯Other:

Legal Name: (Last) (First) (Middle)

Mailing Address: (Street / PO Box) | **Home Phone:** Include Area Code

City: | **State:** | **Zip Code:** | **County:** | **Cell Phone:** Include Area Code

Date of Birth: dd/mm/yyyy | **Age:** | **Sex:** ◯M ◯F | **Marital Status:** (Circle One) ◯Single ◯Married Widowed◯ ◯Separated ◯Divorced

Social Security Number:

Check one if appropriate: ☐Guarantor is disabled, not employed ☐Guarantor is a full-time student, not employed

Guarantor's Employer | **Guarantor's Occupation**

Work Phone: | **Email:**

Printed Name

Signature of Patient/Guarantor

Patient Label

treasure valley hospital

☐ Patient does not have insurance

PERSONAL INSURANCE INFORMATION

Primary Insurance Name:		Secondary Insurance Name:	
Subscriber's Name		Subscriber's Name	
Policy ID Number	Group Number	Policy ID Number	Group Number
Subscriber's Relationship to Patient ◯Self ◯Spouse ◯Child ◯Other:		Subscriber's Relationship to Patient ◯Self ◯Spouse ◯Child ◯Other:	
Subscriber's Date of Birth		Subscriber's Date of Birth	

WORKER'S COMPENSATION INSURANCE INFORMATION

Worker's Compensation Insurance Carrier		
Address (Street-City-State- Zip)		Phone Number
Date of Injury	Time of injury	State where injury occurred
Have you filed a worker's compensation claim? ◯YES ◯NO	Claim Number and Adjuster's name and phone number	

LIABILITY INSURANCE INFORMATION

Your Liability Carrier		Other party's Liability Carrier	
Address (Street-City-State-Zip)		Address (Street-City-State-Zip)	
Have you filed a claim with a Liability Carrier? ◯YES ◯NO		Name of other Party	
Claim Number	Time of Injury	Claim Number	Time of Injury
State	Date of Injury	State	Date of Injury

I hereby verify that all of the above information is correct to the best of my knowledge and understand that if any information is to change, it is my responsibility to inform Treasure Valley Hospital before any services are provided. Worker's compensation and Personal Auto Medical insurer is primary payer only for those services related to the accident. Liability insurance is primary payer only for those services related to the liability settlement, judgment or award; a lien will be filed with the Third Party carriers with all liability claims.

Signature _____

Date: _____

Patient Label