East Valley Hospital
Medical Center

FINANCIAL DISCLOSURE

PATIENT'S DEMOGRAPHIC INFORMATION

PATIENT NAME:	AGE:	DATE OF BIRTH:	SOCIAL SECURITY:	
CURRENT ADDRESS:		HOME PHONE NUMBER:	CELL PHONE NUMBER:	
		YEARS AT THIS ADDRESS:	CIRCLE ONE OWN / RENT	
PREVIOUS ADDRESS: (IF LESS THAN 5 YRS AT ABOVE ADDRESS)				YEARS AT THIS ADDRESS:
EMPLOYER'S NAME:	YEARS EMPLOYED:	DEPARTMENT:	OCCUPATION / TITLE	
EMPLOYER'S ADDRESS:		EMPLOYER PHONE NO:	HOURLY RATE:	PAY DATE:
NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:		RELATIVE'S ADDRESS:		
HOME PHONE:	CELL PHONE NUMBER:			
NAME AND AGE OF ALL HOUSEHOLD DEPENDENTS:				

RESPONSIBLE PARTY'S INFORMATION

RESPONSIBLE PARTY'S NAME: RELATIONSHIP TO PATIENT:	AGE:	DATE OF BIRTH:	SOCIAL SECURITY:	
CURRENT ADDRESS:		HOME PHONE NUMBER:	CELL PHONE NUMBER:	
		YEARS AT THIS ADDRESS:	CIRCLE ONE OWN / RENT	
PREVIOUS ADDRESS: (IF LESS THAN 5 YRS AT ABOVE ADDRESS)				YEARS AT THIS ADDRESS:
EMPLOYER'S NAME:	YEARS EMPLOYED:	DEPARTMENT:	OCCUPATION / TITLE	
EMPLOYER'S ADDRESS:		EMPLOYER PHONE NO:	HOURLY RATE:	PAY DATE:

SPOUSE'S INFORMATION

SPOUSE'S NAME:	AGE:	DATE OF BIRTH:	SOCIAL SECURITY:	
CURRENT ADDRESS:		HOME PHONE NUMBER:	CELL PHONE NUMBER:	
		YEARS AT THIS ADDRESS:	CIRCLE ONE OWN / RENT	
PREVIOUS ADDRESS: (IF LESS THAN 5 YRS AT ABOVE ADDRESS)				YEARS AT THIS ADDRESS:
EMPLOYER'S NAME:	YEARS EMPLOYED:	DEPARTMENT:	OCCUPATION / TITLE	
EMPLOYER'S ADDRESS:		EMPLOYER PHONE NO:	HOURLY RATE:	PAY DATE:

FINANCIAL INFORMATION

CHECKING ACCOUNT NUMBER:	BANK:	BRANCH ADDRESS:	BALANCE:
SAVINGS ACCOUNT NUMBER:	BANK:	BRANCH ADDRESS:	BALANCE:
CREDIT UNION ACCOUNT NUMBER:	BANK:	LOCATION:	BALANCE:
AUTOMOBILE:	BANK:	BRANCH ADDRESS:	PRESENT VALUE:
AUTOMOBILE:	BANK:	BRANCH ADDRESS:	PRESENT VALUE:
HOME:	MORTGAGE HOLDER:	BRANCH ADDRESS:	PRESENT VALUE:
LIFE INSURANCE:	FACE VALUE:	AGENT NAME:	CASH VALUE:
HOUSEHOLD FURNITURE:	HOMEOWNER'S INSURANCE NAME:		COVERAGE AMOUNT:
OTHER SAVINGS / INVESTMENTS:			VALUE:
OTHER SAVINGS / INVESTMENTS:			VALUE:
		TOTAL ASSETS	$

INCOME AND EXPENSES

		BANKRUPTCY OR GARNISHMENT WITHIN 3 YEARS: Y / N			
MONTHLY NET INCOME FROM PATIENT'S EMPLOYER	$	INDEBTED TO (TYPE OR NATURE OF DEBT)	CREDIT LIMIT / LOAN AMOUNT:	CURRENT BALANCE:	MONTHLY PAYMENT:
			$	$	$
MONTHLY NET INCOME FROM RESPONSIBLE PARTY'S EMPLOYER	$		$	$	$
			$	$	$
MONTHLY NET INCOME FROM SPOUSE'S EMPLOYER	$		$	$	$
			$	$	$
OTHER NET MONTHLY INCOME (LIST ALL)	$		$	$	$
TOTAL MONTHLY INCOME	$	**TOTAL MONTHLY EXPENSES**			$

I / We certify the above information is complete and accurate to the best of my / our knowledge. I / We authorize East Valley Hospital Medical Center to contact the above employer's) to verify accuracy of the employment information provided. I / We further authorize the above named hospital to request a credit report to verify accuracy of the creditor information provided above.

I / We understand that failure to provide accurate and complete financial information may result in denial of the credit terms which I / we are requesting by completion of this financial disclosure.

SIGNATURE OF PATIENT & DATE

SIGNATURE OF RESPONSIBLE PARTY & DATE

SIGNATURE OF SPOUSE/ CO-SIGNER & DATE

SIGNATURE OF HOSPITAL REPRESENTATIVE & DATE

HOSPITAL USE ONLY

REVIEWED BY:

PROOF PROVIDED: Y / N

CREDIT BUREAU: Y /N

DISPOSITION: