MAINLINE HEALTH SYSTEMS, INC.

Patient Information

Patient Social Sec. #_________________________ Date_____________________________

Name ______ Race ______ Sex ______ Date of Birth ______ Age ______

Address ______ Township ______ Telephone # ______

Name of Insurance Co. ______ Group# ______ Claim # ______

Address for filing claim ______ Social Security # ______

Person responsible for paying bill ______ Social Security # ______ Relationship ______

Address ______ Telephone # ______

Name of employer ______ Address ______

Emergency Contact ______ Relationship ______

If responsible party is not a parent or legal guardian:
I voluntarily accept responsibility for payment for medical services provided.
_____________________________________ by Mainline Health Systems, Inc. ________________________________
(Signature of Responsible Party)

During the past 24 months, have you, or the family member upon whom you are dependent:

-been hired to do farm or farm related work?	Yes	No
-done farm work year-round/seasonal?	Year-round	Seasonal
-derived the greatest portion of you work related income from farm work?	Yes	No
-moved (established a temporary residence) in order to do farm work?	Yes	No

1. I ____, the ______________________ of ______________________
(Name of person giving consent) (Relationship)

   hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of X-ray, heart tracing and administration of medications prescribed by the physician.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, their assistants including nurses and aides as is necessary in the medical staff's judgment.
3. Release of Information: (a) I authorize the clinic to release medical information to the third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care. (b) I further authorize the release of medical information about treatment here to by (his/her) doctor or any designated by me.
4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.
5. This form has been fully explained to me and I understand its contents.

____ ____
Signature of patient or person authorized to consent for patient Signature of person who explained the contents of this consent form

If the patient is a minor or is unable to consent, complete the following:

A. Patient is a minor _______________ years of age ______________________________ ___________________________
Father's Name Mother's Name

B. Patient is unable to consent because ____

______________________________ ______________________________ ______________________________
Signature of Closest Relative Relationship Witness to Representative