

**DR. JOHN WARNER HOSPITAL
CLINTON, ILLINOIS**

FINANCIAL STATEMENT

Date _____ Inpatient Services Outpatient Services

Name	Spouse	No. of Dependents	Ages of all Family Members	Pt. No.
Address			Home Phone	
Employer Name	Employment Start Date		Employer Address/Phone	
Employer-Spouse	Employment Start Date-Spouse		Employer Address/Phone-Spouse	
Real Estate-Own Y/N Address - Rent Y/N	Real Estate Address	Value	Financed - Bal. Due	
Auto-Make-Year		Value	Financed - Bal. Due	
Life Insurance		Cash Value	Health Insurance Co.	
Stocks & Bonds-Descrip.		Value		
Bank Accounts-Name		Checking Bal.	Savings Bal.	
Monthly Income-Source	Amount	Monthly Obligations	Amount	Hospital Use Only
Employment Gross		Rent		Amount Charges
Interest & Dividends		Mortgage		Amount Insurance Paid
Property Rental		Food		Amount Paid by Patient
Public Assistance		Utilities		Patient's Last Paymt. Date
Social Security		Insurance		Balance Due on Accounts
Unemployment Benefits		Clothing		Outpatient From-To
Disability		Medical Bills		Inpatient From-To
Other - Describe		Misc. Expenses-List on Page 2		
Total Monthly Income		Total Monthly Exp.		

I certify that the above statements are correct to the best of my knowledge, and hereby authorize Dr. John Warner Hospital to contact any of the above listed firm(s) or person(s) to verify accuracy of application.

Signature of Patient/Guarantor

If not signed by patient, state reason

