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	Employer Address	Employer Phone
Employer-Spouse	Employer Address-Spouse	Employer Phone-Spouse

Real Estate-Own Y/N Address - Rent Y/N	Real Estate Address	Value	Financed - Bal. Due

	Value	
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.		

Please attach a copy of your most recently completed Federal Income Tax Return with signatures.
If no Income Tax Return is attached, please explain why____

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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**

CREDITORS	DATE INCURRED	AMOUNT DUE	MONTHLY PAYMENT	REMARKS

Social Situation:

Proposed Repayment of Dr. John Warner Hospital Debt:

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