CMH *Where your health comes first!*

Community Memorial Hospital
PO Box N, 1579 Midland Street
Syracuse, NE 68446

(402) 269-2011
syracusecmh.org
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**Name:**_____ **Maiden Name:**_____
**First** **Middle** **Last**

**SSN:**_____-_____-_____ **Birthdate:**_____ **Gender:** ○ Male or ○ Female

**Home Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Home Phone: (  )** _____ **Cell Phone: (  )** _____ **Work Phone: (  )** _____

**E-Mail:**_____

**Ethnicity:** ☐ Hispanic / Latino or ☐ Non Hispanic / Latino **Preferred Language:** _____

**Race:** ☐ White ☐ Black ☐ Asian/Pacific Island ☐ American Indian ☐ Hispanic ☐ Other:_____

**Status:** ☐ Married ☐ Single ☐ Divorced ☐ Student ☐ Widow ☐ Other:_____

**Employer/Institution:**_____**Occupation:**_____**Work Phone: (  )** _____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____ ○ Full or ○ Part-Time

**Name of Spouse:**_____**SSN:**_____-_____-_____ **Birthdate:**_____

**Employer/Institution:**_____**Occupation:**_____**Work Phone: (  )** _____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____ ○ Full or ○ Part-Time

**In case of emergency, contact:**_____ **Relationship:**_____

**Home Phone: (  )** _____ **Cell Phone: (  )** _____ **Work Phone: (  )** _____

***Complete this section only if someone other than the patient is financially responsible.***

**Responsible Party:**_____ **Relationship to patient:**_____

**SSN:**_____-_____-_____ **Birthdate:**_____

**Home Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Home Phone: (  )** _____ **Cell Phone: (  )** _____**Work Phone: (  )** _____

**Employer/Institution:**_____**Occupation:**_____

**Employer/Institution Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

***By signing below, I verify the Patient Demographic information on this page is accurate and acknowledge that I have reviewed, understand and freely agree to the statements below.***

I consent to such diagnostic therapeutic procedures and physician care with the acknowledgement that no guarantees have been made to me as a result of treatments of examinations.

I give permission to Community Memorial Hospital d/b/a Syracuse Medical Center and d/b/a Weeping Water Medical Center to file my claims with my insurance and also for my consent for the release of any medical information necessary to process my claims. I hereby authorize payment of medical benefits directly to Community Memorial Hospital d/b/a Syracuse Medical Center and d/b/a Weeping Water Medical Center.

I understand that I am financially responsible for the fees that Medicare, insurance or other third party payers do not cover for services provided.

I understand that Syracuse Medical Center and Weeping Water Medical Center is not responsible for my personal valuables. This form has been fully explained to me and I certify that I understand its contents.

**Patient Signature:**_____ **Date:**_____

**Parent/Guardian Signature:**_____ **Date:**_____