## **APPLICATION FOR HELPING HAND MEMBERSHIP**

Name:(Last)	(First)	(Middle)		(Goes by)	
Birth Date: (mo-day-yr)	Age S	Sex Soc.	Sec. No		
Marital Status: Divorced □ Sin	gle □ Widowed □	Married □	Separated □		
Street Address or RFD					
City		State		Zip Code	
Area Code/Phone Number	Church Preference				
Personal Physician	Phone Number				
Prior Hospitalization Date		Hospital			
Your Employer		City/State _		Phone NO	
Spouse's Employer	_ SS#	City/State	P	hone NO	
NAME OF SPOUSE OR NEAREST	RELATIVE TO BE CO	NTACTED IN CA	ASE OF EMERG	ENCY?	
Name	Relationship	Home Ph	one	Business Phone	
2nd Person					
INSURANCE INFORMATION (Please separate policies.	e print clearly) List ALL ir	surance coverages	s if husband and	wife are covered unde	
MEDICARE: Number	Name		Effective date	e:	
MEDICAID: Number		Name _			
BLUE CROSS: ID #	Account #	Be	enefit Code	Plan Code _	
City/State of Plan		Name of Subscrib	ber		
GROUP HOSPITAL INSURANCE					
Name of Ins. Co		Policy No			
Address		City/State			
Name Policy Holder					
Name of Employer		Phone			
PRIVATE INSURANCE					
Name of Ins. Co.		Palicy No			
Address				Phone	
Name of Policy Holder		-			
CURRENT MEDICAL CONDITIONS					
COMPANIENT MEDICAL CONDITIONS	e (le fleatt disease, diab	etes, etc)			
ALLERGIC TO:					
				BLOOD TYPE:	

## ASSUMPTION OF RESPONSIBILITY FOR CORRECTNESS—YOU MUST SIGN TO VALIDATE

I hereby acknowledge that all the information submitted on this form was provided by me or my legal representative and that the information is true to the best of my knowledge. I take total responsibility for all information recorded. I also understand that my Deaconess Hospital Medical Information Card will contain some information from this same form which could be used by medical/rescue personnel in an effort to provide me with proper treatment. Because Deaconess Hospital and its emergency personnel are not responsible in any way for the medical information contained on this form and which appears on my Deaconess Hospital Medical Information Card, I hereby agree, on my own behalf, and on behalf of my heirs, successors, or assigns, not to assert any claims against Deaconess

Hospital, and its emergency personnel, suppliers, personnel and/or subcontractors and employees, or any other endorsing company or group (and their respective officers, directors, employees, successors, and affiliates), in law, in equity or otherwise or liability arising from or in connection with (a) any inaccuracy or omission of information provided on this form, (b) the performance or lack of performance of any service relating to the form or my Deaconess Hospital Medical Information Card, and (c) any damage to my Deaconess Hospital Medical Information Card (or components thereof). I understand this agreement is binding upon me my legal heirs, successors or assigns.

Date	nature	
F-3923* (10-96)		