Hartford Hospital Downtime Sheet

☐ In-patient	☐ Day-Patient	☐ Out-patient TC	Account Number	Med Rec Nbr
Diagnosis/Complaint	Indication	If Preg. LMP		Expected Arrival Date
Registration MD	Primary Care MD	Attending MD		Referring MD

Name Prefix	Patient Last Name	Patient First Name	Patient Middle Name	Name Suffix
Street Address	City	State	Country	Zip Code
Date of Birth	Social Security #	Patient Maiden Name		Mother's Name

Home Phone Other Phone	Other Phone Use ☐ 2nd line ☐ Neighbor ☐ _____	Sex	Race	Marital Status ☐ (S)Single ☐ (W)Widowed ☐ (M)Married ☐ Unknown ☐ (D)Divorced ☐ (X)Legal Separation

Patient's Religion (Check One) This will be shared with your place of worship if they request it.	Church & Location Faith is Practiced

Employer	Employer Address	Employer Tel. #

Employer Contact	Occupation	Length of Employment	Date of Retirement	Onset of Illness Date

Accident/Injury Info A.M. DATE: TIME P.M.	Check One

Person Financially Responsible For Bill/Guarantor	Guar Sex ☐ Male ☐ Female	Guarantor Tel #	Pt. Relationship to Guarantor
Guarantor Address			Guar Social Security #
Guarantor Employer	Employer Address	Employer's Phone	

Emergency Contact #1 Name	Contact Sex ☐ Male ☐ Female	Contact Home Phone	Contact Work Phone
Contact Address			Relationship to Patient
Emergency Contact #2 Name	Contact Sex ☐ Male ☐ Female	Contact Home Phone	Contact Work Phone
Contact Address			Relationship to Patient

Primary Insurance Company	Insurance Group #		Policy Number		AUTHORIZATION #
Street Address	City	State	Country	Zip Code	Insurance Telephone #
Subscriber's Name					
Subscriber's Employer Address		Telephone #			Relationship to Patient
Subscriber's Employer			Employment Status ☐1 F.T. ☐ 3 Unemp ☐ 5 Ret. ☐. 9 Unk ☐ 2 P.T. ☐ 4 Slf Emp ☐ 6 Military		
Subscriber's Employer Address			Employer's Tel. #		

Secondary Insurance Company	Insurance Group #		Policy Number		AUTHORIZATION #
Street Address	City	State	Country	Zip Code	Insurance Telephone #
Subscriber's Name					
Subscriber's Employer Address		Telephone #			Relationship to Patient
Subscriber's Employer			Employment Status ☐1 F.T. ☐ 3 Unemp ☐ 5 Ret. ☐. 9 Unk ☐ 2 P.T. ☐ 4 Slf Emp ☐ 6 Military		
Subscriber's Employer Address			Employer's Tel. #		

If you have **Medicare** please complete the following questions:	
1. Is this illness due to a Worker's Compensation?	☐ Yes ☐ No
2. Is this illness/injury covered by the Black Lung Program?	☐ Yes ☐ No
3. Are you a member of the Health Member Organization (HMO)?	☐ Yes ☐ No
If yes, which program? ____	
4. Is this illness/injury due to a motor vehicle accident?	☐ Yes ☐ No
5. Do you feel that another party is responsible for this illness/injury?	☐ Yes ☐ No
6. Are you covered by an Employer Group Health Plan?	☐ Yes ☐ No
If yes, which plan? ____	
Does your employer employ 20 or more employees?	☐ Yes ☐ No
7. Are you over the age of 65?	☐ Yes ☐ No
8. Are you or your spouse actively employed?	☐ Yes ☐ No
If yes, Employer & address? ____	
Does employer employ 20 or more employees?	☐ Yes ☐ No
9. Are you covered by Medicare solely on the basis of disability?	☐ Yes ☐ No
10. Is a family member currently employed?	☐ Yes ☐ No
If yes, which family member? ____	
Employer & address? ____	
11. Are you covered by Medicare solely on the basis of End Stage Renal Disease?	☐ Yes ☐ No
If yes, have you had a Kidney Transplant?	☐ Yes ☐ No
If yes, when? ____	
12. Have you been confined to a hospital of a skilled nursing facility in the last 60 days?	☐ Yes ☐ No
If yes, Name of facility? ____	
Address: ____	
Admit Date: _____ Dischg. Date: ____	
13. Are you covered by VA benefits?	☐ Yes ☐ No

This portion should be completed if the patient does not have any assistance or insurance. By completing this portion the patient may qualify for a sliding scale payment method.

PAYSCALE INFORMATION IS FOR OUTPATIENT CLINIC ACCOUNTS ONLY		
Weekly Income: $	Total Savings: $	Total Medical Debts: $
Monthly Rent/Mortgage: $	Number of Dependents (including yourself):	