APPLICATION FOR ENTRANCE

ST. VINCENT'S HOSPITAL, GREEN BAY, WIS.

Applicant No. _____ Terms _____

Accepted Yr. 1955 Month 6 Day 5 Hour 12:15 AM

Have you been in Hospital before _____ When _____ Under what name _____

DATA FOR CLINICAL RECORD

Name _____ Husband or wife _____

Address 1095 Hazel Father _____

Tel. _____ Birthplace _____

City or town _____ Mother _____

Birthplace _____

Age 2 Birthday 1-23 Birthplace _____ Sex F Color W

Religion _____ Single _____ Married _____ Widowed _____ Divorced _____ Sep. _____ Children _____

Attending Doctor _____ Referred by Doctor _____

Subjective Diagnosis _____ Tentative length of stay _____

Division _____ Room _____ Private _____ Semi-private _____ Ward _____

PATIENT'S STATEMENT

Employed by _____ Insurance benefits—Hospitalization _____ Accident _____ Life _____

Address _____ Tel. _____ Name of Company _____

How long there _____ Address _____

What is your position _____ Dept. _____ _____ Policy No. _____

Salary, wages or income $ _____ Per week _____ Month _____ Real Estate _____

ACCIDENT OR COMPENSATION

Nature of Accident _____ Place _____ Time _____

Employer or Participants _____ Tel. _____

Address _____ City or town _____

Name of Insurance Company involved _____ Doctor called _____

Address _____

Hospital service is hereby authorized Signature _____

SOCIAL SERVICE

Have you or are you receiving assistance _____ How long at present address _____

From whom _____ Township, City, County or Agency _____

_____ Supervisor's Name _____

Nature and amount _____ Has Supervisor been notified _____

Remarks _____

AGREEMENT FOR PAYMENT

_____, the undersigned do hereby expressly guarantee payment in full of any and all charges for hospital services rendered to _____

_____

As follows: $_____ Every WEEK beginning _____

$_____ Semi-monthly, beginning _____

$_____ Monthly, beginning _____

OR; Account in full when leaving the hospital _____

OR: _____

_____

In the event payment is not made as specified above, it is hereby agreed to notify the Hospital office of the reason therefor, BEFORE the date when payment is due and if this is not done, it is further agreed that this instrument shall act at an order to _____ employer _____ for the portion of _____ compensation to cover the payments agreed upon.

Date _____ 19____ _____ [SEAL]

WITNESS _____ _____ [SEAL]

Hospitalization Insurance—The Patient must make arrangements to pay the hospital the difference between the regular bill and the amount allowed by his company or association.

(Form No. 38)