PATIENT FINANCIAL ASSESSMENT STATEMENT

RESPONSIBLE PARTY: LAST FIRST MIDDLE

PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY

HOSPITAL ACCOUNT # (S):

SPOUSE

NUMBER OF DEPENDENTS

STREET ADDRESS

HOME PHONE ☐ MOBILE PHONE ☐
( )

CITY, STATE & ZIP

WORK NUMBER
( )

OCCUPATION:

EMPLOYER (IF SELF EMPLOYED, DESCRIPTION):

SOCIAL SECURITY #:

ADDRESS

YEARS AT EMPLOYER

SALARY $____________ HOURLY ☐ BIWEEKLY ☐ MONTHLY ☐
OTHER INCOME: ____________________
SOURCE:____________________

SPOUSE

OCCUPATION:

EMPLOYER (IF SELF EMPLOYED, DESCRIPTION):

SOCIAL SECURITY #:

ADDRESS

PHONE

YEARS AT EMPLOYER

SALARY $___________ HOURLY ☐ BIWEEKLY ☐ MONTHLY ☐

OTHER INCOME:

SOURCE:

ASSETS

CASH ON HAND $________________
CHECKING ACCOUNT* $________________
SAVINGS ACCOUNT* $________________
CREDIT UNION ACCOUNT* $________________
REAL ESTATE EQUITY $________________
MOTOR VEHICLE (S) $________________
MAKE / YEAR ____________ VALUE $__________
MAKE / YEAR ____________ VALUE $__________
TRUST ACCOUNTS $________________
OTHER SOURCES: $________________
(STOCK, BONDS)

LIABILITIES / MONTHLY TOTALS

MORTGAGE / RENT PAYMENT $_______________
INSURANCE PREMIUMS:
AUTOMOBILE (S) ☐ MEDICAL ☐ HOME ☐
$_______________
OTHER: _____________________________________
UTILITIES:
GAS ☐ ELECT. ☐ WATER ☐ PHONE ☐ $_______________
AUTOMOBILE (S) PAYMENT $_______________
FOOT $_______________
OTHER LIABILITIES:
DESCRIPTION PAYMENT BALANCE
______________ ____________ $__________
______________ ____________ $__________
______________ ____________ $__________

*BANK BRANCH (ES) & ACCOUNT NUMBERS:

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OR PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA. I AUTHORIZE/CONSENT HOAG ORTHOPEDIC INSTITUTE TO VERIFY MY CREDIT INFORMATION

____ ____________

SIGNATURE DATE

pfaEnglish12.2014