



**Foundation Surgical Hospital**  
 5410 West Loop South  
 Bellaire, Texas 77401

**PATIENT INFORMATION**

Patient #	Admit #	Admit Date	Admit Time	Room/Bed	Patient Type			FC	Legal Status
Patient Name (Last, First, Int)				Birthdate	AGE	SEX	MS	Race	SS#
Patient Address				City	State	Zip	Telephone #		
Patients Occupation				Employer Name			Employer Telephone #		
Notify in Emergency / Relationship				Emergency Telephone # _____ or _____					
Next of Kin / Relationship						Next of Kin Telephone # _____			
Referral Source	Admitting MD			Attending MD			Last Hosp IP Discharge		

**GUARANTOR INFORMATION**

Guarantor Name (Last, First, Int)			SS#		Birthdate	Sex
Guarantor Address			City	State	Zip	Telephone #
Guarantors Occupation			Employer Name		Employer Telephone #	
<b>FC/PAYOR CODE</b> <b>PAYOR NAME</b> <b>INSURANCE ADDRESS</b>  <b>INSURED</b> <b>CERT-SSN-HIC-ID NO.</b> <b>GROUP #</b> <b>TREATMENT AUTH #</b>	<b>PRIMARY</b>		<b>SECONDARY</b>		<b>TERTIARY</b>	
	ADMITTING DIAGNOSIS DESCRIPTION					TAR NUMBER

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Clerk's Initials: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

\_\_\_\_\_  
*Attending MD*