MERCY
MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

DENTAL CLINIC - MMC

FINANCIAL STATEMENT

PATIENT NAME & SOCIAL SECURITY NO.	AGE	NO. IN FAMILY	DATE OF BIRTH	SPOUSE/PARENT	PHONE

PATIENT ADDRESS	CITY, STATE, ZIP	PATIENT EMPLOYER	HOW LONG?

GUARANTOR & SOCIAL SECURITY NO.	GUARANTOR ADDRESS	GUARANTOR EMPLOYER	HOW LONG?

FRIEND/RELATIVE OUTSIDE HOME	RELATIONSHIP	ADDRESS & PHONE

INSURANCE COVERAGE	POLICY HOLDER	☐ CHECKING BALANCE:	☐ SAVINGS ☐ OTHER BANK:

☐ RENT ☐ OWN ☐ BUY IN ☐ C/O RELATIVES	LANDLORD / MORTGAGE HOLDER	BALANCE	VALUE

GROSS INCOME

(Please include copies of income either 3 or 12 months prior to date(s) of service.)

PATIENT _____
SPOUSE _____
SOC. SEC. _____
UNEMP. _____
PENSION _____
CHILD SUPPORT _____
WORKER'S COMP. _____
OTHER _____
_____
_____

TOTAL INCOME: _____
YEARLY GROSS INCOME: _____

BASIC MONTHLY EXPENSES

HOUSING _____
GAS _____
ELECTRIC _____
WATER _____
PHONE _____
FOOD _____
TRANSP. EXPENSE _____
MEDICAL _____
MEDICAL _____
PHARMACY _____
INSURANCE _____
CHILD CARE _____

SUBTOTAL: _____

OTHER EXPENSES

CABLE TV _____
CAR PAYMENT _____
VISA _____
MASTERCARD _____
LOAN _____
LOAN _____
_____
_____
_____
_____
_____

SUBTOTAL: _____

TOTAL EXPENSE: _____

REMARKS: Please use space on back for additional comments.

PROOF OF INCOME PROVIDED
☐ PAYSTUB ☐ TAX FORM ☐ OTHER _____

PATIENT NUMBER(S)

SIGNED: _____
MANAGER, PATIENT ACCOUNT SERVICES

_____
DATE

SIGNED: _____
DIRECTOR, PATIENT ACCOUNT SERVICES

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNED _____ OR _____ _____ _____
PATIENT'S SIGNATURE | SIGNATURE OF PERSON COMPLETING FORM | RELATIONSHIP | DATE