Western Carolina Digestive Consultants, P.A. & Endoscopy Center, LLC

# Patient Financial Assessment Form

Date: _____ Account #: _____
Social Security #: _____
Patient last name: _____ First name: _____
Address: _____ City: _____
State: _____ ZIP: _____
Phone #: _____ Alternate phone #: _____
Name of responsible party (if not patient, print name Guarantor): _____
Patient's employer: _____
Employer phone #: _____
Employer address: _____ City: _____
State: _____ ZIP: _____
Length of employment: _____ If unemployed, last date of employment: _____

Spouse last name: _____ First name: _____
Spouse employer: _____ Employer phone #: _____
Spouse Employer address: _____ City:_____
State: _____ ZIP: _____
Length of employment:_____
Total in household (include yourself):_____
Adults (18+):_____ Minors (under 18):_____

Guarantor (responsible party) last name: _____ First name: _____
Guarantor Employer: _____
Guarantor Employer Phone #:_____
Guarantor Employer address: _____
City:_____
State: _____ ZIP: _____
Length of employment:_____ If unemployed, last date of employment:_____