SAN GORGONIO MEMORIAL HOSPITAL
STATEMENT OF FINANCIAL CONDITION

ALL FIELDS MUST BE FILLED OUT AND ALL DOCUMENTATION REQUESTED MUST ACCOMPANY THE APPLICATION FOR IT TO BE PROCESSED.

PATIENT NAME_____ SPOUSE NAME _____

ADDRESS_____ PHONE _____

PATIENT SSN_____ SPOUSE SSN _____

FAMILY STATUS: List all dependents that you support:

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer:_____ Position_____

Contact Person & Telephone_____

If self employed, Name, address and type of Business_____

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