PHYSICIAN FINANCIAL ASSISTANCE APPLICATION

Tri-State Orthopaedic Surgeons, Inc.
225 Cross Lake Drive
Evansville IN 47715
(812) 477-1558

Please complete this form accurately and completely. (Please print)

Account # : _____ **Patient Name:** _____

Date of Birth: _____ **Phone No.** _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Marital Status: (M) ___ (S) ___ (D) ___ (W) ___**

Social Security: _____ **Employer:** _____

Employers Phone No.: _____ **How long employed there?** _____

Previous Employer: _____

Retired: YES NO FROM WHERE? _____

(If you are under 18 years old we need both parents information, if married we need your spouse information.)

Husband/Fathers name: _____ **Social Security No.:** _____

Date of Birth: _____ **Employer:** _____

How Long Employed There? _____ **Employer Phone No:** _____

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Wife or Mothers Name: _____ **Social Security No.:** _____

Date of Birth: _____ **Employer:** _____

How Long Employed There?: _____ **Phone No.:** _____

First name of Legal Dependents under the age of 18 or still in High School. **Age of Dependent:**

_____ _____

_____ _____

_____ _____

_____ _____

ASSETS:

Bank Accounts:

Checking Account Balance: $_____
Name of Bank _____

Savings Account Balance: $_____
Name of Bank: _____

Do you RENT or OWN your home

Home Market Value $_____

Auto: Year _____ **Make** _____
Auto: Year _____ **Make** _____
Auto: Year _____ **Make** _____

Name of Credit Card _____
Credit Card Limit $_____
Credit Card Balance $_____

Name of Credit Card: _____
Credit Card Limit $ _____
Credit Card Balance $_____

(List any other assets or credit cards on the back of this form.)

(if you are under 18 years old we need both parents info, if married we need you and your spouse info.)

MONTHLY INCOME:
Yourself or Father (if minor) **$**_____
Social Security #: _____
SSI Benefits: $_____
Child Support: $_____
Veterans Benefits: $_____
Retirement Income: $ _____
Unemployment Benefits: $_____
Interest Income: $_____

MONTHLY INCOME:
Spouse or Mother (if minor) **$**_____
Social Security#: _____
SSI Benefits: $_____
Child Support: $_____
Veterans Benefits: $_____
Retirement Income: $_____
Unemployment Benefits: $_____
Interest Income: $_____

WE MUST HAVE THE following items with this form: COPIES OF YOUR LAST BANK STATEMENT, copies of the last 3 pay stubs from you and your spouse or both parents if patient is a minor. AND a copy of the previous years income tax return.

I so solemnly state that the information contained herein is true and accurate to the best of my knowledge and belief. I understand TSOS may check my credit and employment history.

Date: _____ **Signature:** _____ **(Patient/Parent/Spouse/Guardian)**

Please make sure both sides are fully completed. If not it will be returned to you for completion and no discounts or consideration will be given until all information is received.