

# 2009 PATIENT INFORMATION FORM

This form is required of any person attending any program at Robert S. Lyle Scout Reservation and must accompany the original medical health form. The hospital & clinic that serves our camp requires this form. Every camp participant's records will be checked upon arrival in camp.

## PATIENT INFORMATION

Name: \_\_\_\_\_ (Maiden) \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ County of Residence: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Married/Single: \_\_\_\_\_ Student: Y / N Male/Female: \_\_\_\_\_

## ATTENTION HEALTH CARE PROVIDER COUNCIL'S INSURANCE INFORMATION

Boy Scouts of America Accident & Sickness Insurance can only be filed after patient's receipt of personal health insurance explanation of benefits. Patient then must submit copy of the itemized bill. Please be sure to provide the patient the itemized statement to file claim.

## **This form is for Robert S. Lyle Scout Reservation Campers Only!**

### PATIENT'S INSURANCE INFORMATION

Subscriber (Parent/Guardian): \_\_\_\_\_  
 Address/City/State/Zip: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Telephone/Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Group Name & No.: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Employer: \_\_\_\_\_

### SECOND INSURANCE INFORMATION

Subscriber (Parent/Guardian): \_\_\_\_\_  
 Address/City/State/Zip: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Telephone/Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Group Name & No.: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Employer: \_\_\_\_\_