Captain James A. Lovell Federal Health Care Center
North Chicago, Illinois 60064
507-109 NSN 7540-00-634-4120

MEDICAL RECORD	Report on **Federal Health Care Center Application for Care** ____ or Continuation of S.F. ________________________________ (Strike out one line) (specify type of examination ore data)

(Sign and date)

FULL NAME (Last, First Middle):____

ALIAS:____

SOCIAL SECURITY NUMBER:______________________ MULTIPLE BIRTH:_____YES _____NO

DATE OF BIRTH:__________________________________ MALE__________ FEMALE_______

ADDRESS:_____________________________________

CITY:______________________ STATE:_________

ZIP CODE:____________________ COUNTY:______________

HOME PHONE:____________________________ OFFICE PHONE:___________________

CELL PHONE:____________________________ PAGER:________________________

EMAIL:____

MARITAL STAUS:__________________________ RELIGION:_______________________

PLACE OF BIRTH:____

FATHER:____ LIVING/DECEASED

MOTHER:____ LIVING/DECEASED

MOTHER'S MAIDEN NAME:____

ETHNICITY:______________________________ RACE:__________________________

NEXT OF KIN:_____________________________ RELATIONSHIP:___________________

ADDRESS:______________________________________

CITY:________________________ STATE:_________ ZIP CODE:___________________

PHONE:________________________________ WORK PHONE:_____________________

(Continue on reverse side)

Patient's Identification *(For typed or written entries give: Name—last, first, middle, grade; rank; rate; hospital ore medical facility)*

REGISTER NO.	WARD NO.

REPORT ON ___________ OR CONTINUATION OF______________

Medical Record
STANDARD FORM 507 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.201.1

*U.S. GOVERNMENT PRINTING OFFICE: 2000-560-042/20030
Approved by RCTS: 6/19/09

EMERGENCY CONTACT:

NAME:______________________________________ RELATIONSHIP:______________________________

ADDRESS:____

CITY:____STATE:___________ ZIP CODE:_________________

HOME PHONE: ______________________________ WORK PHONE: ________________________________

PATIENT EMPLOYER:_____________________________ SPOUSE'S EMPLOYER:______________________

ADDRESS:______________________________ ADDRESS:_____________________________________

CITY:_____________________ STATE:_______ CITY:_______________________ STATE:___________

ZIP:_________ PHONE:____________________ ZIP:___________ PHONE:________________________

OCCUPATION:__________________________ OCCUPATION:________________________________

STATUS:______________________________ STATUS:____________________________________

RETIRED DATE:________________________ RETIRED DATE:______________________________

INSURANCE:____

MEDICAID: ________YES ________NO

PATIENT TYPE: _____ACTIVE DUTY_____DEPENDENT_____RESERVIST_____RETIRED____RECRUIT

SPONSOR INFORMATION:

NAME:_____________________________________DATE OF BIRTH:______________________________

SOCIAL SECURITY NUMBER:____

MILITARY STATUS: ________ACTIVE _________RETIRED

BRANCH: ____________________________________ RANK_______________________________________

Assignment of Benefits: I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I herby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Acknowledgement of Department of Veterans Affairs, VHA, Notice of Privacy Practices
The signature below only acknowledges receipt of the VHA Notice of Privacy Practices, effective date 14 April 2009.

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE: ____

DATE: _____________________