

ST MARYS LEWISTON

PATIENT INFORMATION

Patient Name: [Redacted]  
Hospital Acct: [Redacted]  
Address: [Redacted]  
Sex: [Redacted]  
DOB: [Redacted]  
Home Phone: [Redacted]  
Race: [Redacted]  
Language: [Redacted]



Patient MRN: [Redacted]  
Patient CSN: [Redacted]  
Religion: [Redacted]  
Marital Status: [Redacted]  
Age: [Redacted]  
Mobile Phone: [Redacted]  
Employer: [Redacted]  
Admitted/Arrived From: [Redacted]

ADMISSION INFORMATION

Admit Date: 10/25/2023  
Patient Class: Emergency  
Admit Source:  
Admitting Provider:  
Unit: Sml Emergency  
Admission Diagnosis: [Redacted]  
Emergency Complaint: [Redacted]  
Discharge Date:

Admit Time: [Redacted]  
Service: Emergency medicine  
Admit Type: Emergency  
Attending Provider: Hanley, Sara\*  
Room/Bed: [Redacted]  
Discharge Time:

GUARANTOR INFORMATION

Name: [Redacted]  
Phone: [Redacted]

EMERGENCY CONTACTS

Name: [Redacted]

COVERAGE INFORMATION

Primary Insurance: [Redacted]  
Plan Name: [Redacted]  
Claim Address: [Redacted]  
Group #: [Redacted]  
Auth #: [Redacted]

Subscriber: [Redacted]  
Pt Rel to Subscriber: [Redacted]  
Sex: [Redacted]  
Policy #: [Redacted]  
Group Name: [Redacted]  
Ins Phone: [Redacted]

Secondary Insurance:  
Plan Name:  
Claim Address: NA  
Group #: N/A  
Auth #: N/A

Subscriber:  
Pt Rel to Subscriber:  
Sex:  
Policy #: N/A  
Group Name: N/A  
Ins Phone:

Accident Date:

Accident Type:

PROVIDER INFORMATION

PCP: [Redacted]  
Referring Prov:  
Advanced Directive:  
Lab Client:

PCP Phone: [Redacted]  
Referring Phone:  
Referring Fax:  
Research:  
Enrollment Status: [Redacted]