

Opportunity Medical Center

Account #	Admit Date	Admit Time	Reg Init	Brought By	Info Provided By	MR Number
61138	02/17/2022	00:00	EG	Wife	Mother	74010653
Admitting Physician	Primary Care Phys.	Room #	Type	Service	Discharge Date	Time
Jonathan Parker	Kelly Hutchinson	750		Outpatient		
Patient Last Name	First	Middle	Former Name	Race	Rel Pref	Social Security #
Mills	Casey			PI	no	555-18-3400
Patient Address	Apt. No.	City	State	Zip Code	Patient Phone #	
83546 Tracy Lake		East Aaron	MA	02222	(752)834-8524	
Driver's License #	Age	Birth Date	Birthplace	Gender	MS	Occupation
	70	07/21/19	MA	F	F	Dispensing
Accident? Date/Time						
Patient Employer	Employer Address					Employer Phone
Foster, Ramirez and French	37008 Herrera Route					453-089-5385
Spouse Name	Spouse Address			City	State	Spouse Phone
Richard Coleman	2682 Kathleen Port Suite 647			Hayneston	MA	001-993-934-52
Emergency Contact	Relationship	Home Phone	Cell Phone	Work Phone		
Luis Bates	Friend	137-914-2236	137-914-7673			
Admitting Diagnosis	Admit Type			ICD9	Admit Source	
Asthma	Outpatie					
Primary Insurance Plan	Primary Policy #	Authorization #	Primary Policy Holder			
Northern Care	64-6058-0143					
Insurance Plan #2	Secondary Policy #	Authorization #	Secondary Policy Holder			
Eastern Care	945-3941					
Insurance Plan #3	Tertiary Policy #	Authorization #	Tertiary Policy Holder			
Guarantor Name	Rel to Pt	Mailing Address			Guarantor Phone	
Guarantor Occupation	Employer	Employer Address			Employer Phone	
Billing Remarks:						
Principal Diagnosis:					Code:	152834
Secondary Diagnosis:					Code:	
Operations and Procedures:					Physician	Date
Consulting Physician:						
Final Disposition: <input type="radio"/> Discharged <input type="radio"/> Transferred <input type="radio"/> Left AMA <input type="radio"/> Expired <input type="radio"/> Autopsy <input type="radio"/> Yes <input type="radio"/> No						
I certify that my identification of the principal and secondary diagnosis and the procedures performed is accurate to the best of my knowledge.						
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_____ Attending Physician					_____ Date	