Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13009

8 - OTHER

PATIENT REGISTRATION

EMERGENCY

DATE 1/28/98 TIME 16:45

ACCOUNT NO	ADMIT DATE & TIME	AD TYPE	AD SOURCE	ACCT CODE	MAJ	MIN	SERVCD	ROOM NO	MED. RECORD NO.
[redacted]	1/28/98 16:44	1	7		E	E	[redacted]	/	[redacted]

PATIENT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	AGE	SEX	RACE	CHURCH/RELIGION	MAR ST	SMOKE
[redacted]	[redacted]	38Y	F	C	[redacted]	M	

PATIENT ADDRESS	CITY	STATE	ZIP
[redacted]	[redacted]		

PHONE	COUNTY	SOC SEC NO	PREVIOUS NAME	MGH RECORD NO.
[redacted]	[redacted]	[redacted]		[redacted]

EMPLOYER	CITY	STATE	ZIP
[redacted]	[redacted]		

EMERGENCY CONTACT NAME	TELEPHONE	ALTERNATIVE PHONE	RELATIONSHIP
[redacted]	[redacted]	[redacted]	SISTER

ADDRESS	CITY	STATE	ZIP
[redacted]	[redacted]		

ATTENDING DOCTOR NAME	ATT DR #	ADMITTING DOCTOR NAME	AD DR #
[redacted]	[redacted]	[redacted]	[redacted]

PRIMARY CARE DOCTOR NAME	PRIM DR #	PROVISIONAL DIAGNOSIS
[redacted]	[redacted]	

GUARANTOR NAME	SOC SEC. NO.	GUARANTOR PHONE	RELATIONSHIP
[redacted]	[redacted]	[redacted]	HUSBAND

ADDRESS	CITY	STATE	ZIP
[redacted]	[redacted]		

GUARANTOR'S EMPLOYER	CITY	STATE	ZIP
[redacted]	[redacted]		

	INSURANCE 1	INSURANCE 2	INSURANCE 3
CARRIER NAME	[redacted]		
CARRIER NO			
CONTRACT NO.	[redacted]		
GROUP NO			
SERVICE CODE			
PLAN CODE			
SUBSCRIBER NAME	[redacted]		
RELATIONSHIP	HUSBAND		
PAR/REF #			
ADDRESS	[redacted]		
CITY			
STATE/ZIP			
EMPLOYER			
ADDRESS			
CITY	[redacted]		
STATE/ZIP			
PHONE	[redacted]		
RETIRE. DATE			

LAST ADMIT DATE	LAST DISCHARGE DATE	LAST O P REG DATE	LAST E R REG DATE	INFORMATION SOURCE	DUR PW ATTY	LIVING WI
0/00/00	0/00/00	0/00/00	0/00/00			

HOSPITAL NAME	REGISTRATION CLERK
	[redacted]

ADMITTING COMMENTS	DISCHARGE DATE	TIME

PLEASE VISIT THE FOLLOWING DEPARTMENTS	DISCHARGE STATUS	SERV	LOS

DIAGNOSIS	CODE

PROCEDURE	CODE

MEDICAL RECORDS USE ONLY

PRO _____ PAR _____

OTHER _____ RCC _____

000002

PHYSICIAN'S SIGNATURE _____ DATE _____

MEDICAL RECORDS

13009

EXH E 8 of 45

PATIENT REGISTRATION

[redacted]

INPATIENT

DATE 1/28/98 TIME 18:44

ACCOUNT NO	ADMIT DATE & TIME	A D TYPE	AD SOURCE	ACCT CODE	MAJ	MIN	SERVCD	ROOM NO	MED. RECORD NO.
[redacted]	1/28/98 16:44	1	7		I	I	[redacted]	[redacted]	

PATIENT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	AGE	SEX	RACE	CHURCH/RELIGION	MARST	SMOKER
[redacted]	[redacted]	38Y	F	C	[redacted]	M	N

PATIENT ADDRESS [redacted] CITY STATE ZIP

PHONE	COUNTY	SOC. SEC NO	PREVIOUS NAME	INSURANCE RECORD NO.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

EMPLOYER [redacted] STATE ZIP

EMERGENCY CONTACT NAME	TELEPHONE	ALTERNATIVE PHONE	RELATIONSHIP
[redacted]	[redacted]		HUSBAND

ADDRESS [redacted] CITY STATE ZIP

ATTENDING DOCTOR NAME	ATT DR #	ADMITTING DOCTOR NAME	AD. DR #
[redacted]	[redacted]	[redacted]	[redacted]

PRIMARY CARE DOCTOR NAME	PRIM DR #	PROVISIONAL DIAGNOSIS
[redacted]	[redacted]	ACUTE INFERIOR WALL MI

GUARANTOR NAME	SOC. SEC. NO.	GUARANTOR PHONE	RELATIONSHIP
[redacted]	[redacted]	[redacted]	HUSBAND

ADDRESS [redacted] CITY STATE ZIP

GUARANTOR'S EMPLOYER [redacted] CITY STATE ZIP

	INSURANCE 1	INSURANCE 2	INSURANCE 3
CARRIER NAME	[redacted]		
CARRIER NO			
CONTRACT NO.			
GROUP NO			
SERVICE CODE			
PLAN CODE			
SUBSCRIBER NAME	[redacted]		
RELATIONSHIP	HUSBAND		
PAR/REF #			
ADDRESS	[redacted]		
CITY			
STATE/ZIP			
EMPLOYER			
ADDRESS			
CITY	[redacted]		
STATE/ZIP			
PHONE			
RETIRE. DATE			

LAST ADMIT DATE	LAST DISCHARGE DATE	LAST O P REG DATE	LAST E R REG DATE	INFORMATION SOURCE	DUR PW ATTY	LIVING WIL
0/00/00	0/00/00	0/00/00	0/00/00			

HOSPITAL NAME

REGISTRATION CLERK [redacted]

ADMITTING COMMENTS

DISCHARGE DATE 2-3-98 TIME 1530

PLEASE VISIT THE FOLLOWING DEPARTMENTS SEE DRG SHEET

DISCHARGE STATUS Home Med SERV LOC [redacted]

DIAGNOSIS CODE

ACUTE INFERIOR WALL MI

PROCEDURE CODE

000003

MEDICAL RECORDS USE ONLY

PRO _____ PAR _____

OTHER _____ RCC _____

[redacted]

16 Feb 98

DATE

MEDICAL RECORDS

13009

EXH E 1 OF 45