

# Pre-Admit Information

In an effort to expedite the admitting process, please print the information requested below and check the appropriate response for each category. Please return to the admitting department as soon as possible.

**First Pregnancy?**  Yes  No

**Today's date** \_\_\_\_\_

ADMIT OR DUE DATE		DOCTOR		REASON FOR ADMISSION	
PATIENT'S NAME (LAST, FIRST, MI)				MAIDEN NAME	
SOCIAL SECURITY NUMBER		BIRTH DATE		MOTHER'S NAME	
<b>SEX</b> <input type="checkbox"/> FEMALE		<b>RACE</b> <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER _____		<b>RELIGIOUS PREFERENCE</b> <input type="checkbox"/> CATHOLIC <input type="checkbox"/> BAPTIST <input type="checkbox"/> LUTHERAN <input type="checkbox"/> METHODIST <input type="checkbox"/> PRESBYTERIAN	
		<input type="checkbox"/> EPISCOPALIAN <input type="checkbox"/> JEWISH <input type="checkbox"/> MORMON <input type="checkbox"/> OTHER		<b>STUDENT STATUS</b> <input type="checkbox"/> YES, FULL TIME <input type="checkbox"/> YES, PART TIME <input type="checkbox"/> NO	
PATIENT'S HOME ADDRESS (STREET, CITY, ZIP CODE, APT. #)					HOME TELEPHONE NUMBER
EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> RETIRED NAME OF EMPLOYER _____ OCCUPATION _____ EMPLOYER'S TELEPHONE NUMBER _____ EMPLOYER'S ADDRESS (STREET, CITY, ZIP CODE, SUITE#) _____					
<b>RESPONSIBLE PARTY</b> (Policy Holder)			RELATION	BIRTH DATE	SOCIAL SECURITY NUMBER
HOME ADDRESS (STREET, CITY, ZIP CODE, APT. #)					HOME TELEPHONE NUMBER
EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> RETIRED NAME OF EMPLOYER _____ OCCUPATION _____ EMPLOYER'S TELEPHONE NUMBER _____ EMPLOYER'S ADDRESS (STREET, CITY, ZIP CODE, SUITE#) _____					
<b>PRIMARY INSURANCE COMPANY</b>			<b>SECONDARY INSURANCE COMPANY</b>		
NAME OF INSURED INDIVIDUAL			NAME OF INSURED INDIVIDUAL		
RELATION TO PATIENT		GROUP NUMBER	RELATION TO PATIENT		GROUP NUMBER
GROUP NAME			GROUP NAME		
CONTRACT NUMBER OR SOCIAL SECURITY NUMBER			CONTRACT NUMBER OR SOCIAL SECURITY NUMBER		
PHONE NUMBER TO VERIFY		PHONE NUMBER TO PRE-CERTIFY	PHONE NUMBER TO VERIFY		PHONE NUMBER TO PRE-CERTIFY
<b>FATHER OF BABY:</b> NAME (LAST, FIRST, MI)			BIRTH DATE		SOCIAL SECURITY NUMBER
PLACE OF EMPLOYMENT			WHAT INSURANCE WILL YOUR BABY BE COVERED UNDER		
<b>NEXT OF KIN:</b> NAME _____ RELATIONSHIP _____					
HOME ADDRESS (STREET, CITY, ZIP CODE, SUITE#) _____ TELEPHONE NUMBER _____					
<b>PERSON TO NOTIFY:</b> NAME _____ RELATIONSHIP _____					
HOME ADDRESS (STREET, CITY, ZIP CODE, SUITE#) _____ TELEPHONE NUMBER _____					

**PLEASE BRING YOUR INSURANCE IDENTIFICATION CARDS WITH YOU AS POLICY NUMBERS MUST BE ON ALL INSURANCE TO BE FILED.**

**ATTENTION:** If your insurance pays only 80% of your hospital bill, you will be required to pay a deposit at the time of admission. This deposit will be based upon your estimated length of stay and estimated charges. A hospital spokesperson will contact you either by phone or letter regarding this deposit.

**PLEASE COMPLETE AND RETURN PROMPTLY. QUESTIONS? CALL 374-4119 M-F / 8AM-5PM**