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Clear Form

# PRE ADMISSION REGISTRATION
# IN-PATIENT / OUT-PATIENT / AMBULATORY

In order to expedite your admission to the Hospital, we are asking you to fill in the information called for below and return to us promptly. Your admission record will be ready when you arrive. While some of this information may seen unnecessary to you, it is needed by us to locate and identify any medical records of a former admission. If there was one, so that they will be available for your attending physician upon your arrival. Careful identification is necessary because it is not uncommon to have medical records of different patients with the same names (including first names and middle initials) in our files. This form must be submitted prior to the date of service or treatment.

**DIAGNOSIS** _____

**SERVICE** _____

**ESTIMATED LENGTH OF STAY** _____

| SPACES BELOW FOR HOSPITAL USE ONLY | |
|---|---|
| ROOM NO. L.O.C. | PATIENT'S HOSPITAL NO. |
| DOCTOR'S CODE: | GUARANTOR'S NO. |

NAME OF ATTENDING PHYSICIAN:

DATE YOU ARE SCHEDULED FOR ADMISSION:

| FAMILY NAME | FIRST NAME | MIDDLE NAME | PHONE NO. |
|---|---|---|---|
| | | | |

| PATIENT'S ADDRESS: (MAILING / HOME) | SEX | CIVIL STATUS | RELIGION |
|---|---|---|---|
| | M F | S M W D SEP | |

| AGE - YRS | BIRTH DATE MO DAY YR | BIRTHPLACE | CITIZENSHIP OTHERS SPECIFY | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| | | | ( ) US ( ) PERMANENT RESIDENCE CARD NO. | |

| OCCUPATION | EMPLOYER | ADDRESS OF EMPLOYER - - PHONE |
|---|---|---|
| | | |

ARE YOU A OTHER SPECIFY

( ) VETERAN ( ) OFF ISLAND-STUDENT

TRANSIENT: (IF YES EXPLAIN)

( )YES ( ) NO

| NAME OF GUARANTOR/ SS NUMBER | RELATIONSHIP | ADDRESS IF OTHER THAN ABOVE | BIRTH DATE MO DAY YR |
|---|---|---|---|
| | | | |

| OCCUPATION | EMPLOYER | ADDRESS OF EMPLOYER | PHONE NUMBER |
|---|---|---|---|
| | | | |

| NOTIFY IN CASE OF EMERGENCY | RELATIONSHIP | ADDRESS | PHONE NUMBER |
|---|---|---|---|
| | | | |

HAVE YOU EVER BEEN A PATIENT IN THIS HOSPITAL? ( ) YES ( ) NO APPROXIMATE DATE:

MAIDEN NAME OF MOTHER

## INSURANCE INFORMATION

DO YOU SUBSCRIBE TO A HOSPITAL INSURANCE? ( ) YES ( ) NO NAME OF INSURED

ARE YOU ENTITLED TO MEDICAID OR MEDICARE? ( ) YES ( ) NO

| NAME INSURANCE: | CERT. OR SERVICE NO. | ADDRESS OF INSURANCE COMPANY |
|---|---|---|
| | | |

| GROUP NO. | CONTRACT NO. | EFFECTIVE DATE | SUBSCRIBER ( ) FAMILY MEMBER ( ) | DEPENDENT ( ) COMPREHENSIVE COVERAGE ( ) |
|---|---|---|---|---|
| | | | | |

OTHER HOSPITALIZATION INSURANCE COVERAGE

| ADDRESS | CITY | STATE | CERT. OR POLICY NO. | GROUP NO | EFFECTIVE DATE |
|---|---|---|---|---|---|
| | | | | | |