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

..rder to expedite your admission to the Hospital, we are asking you to fill in the information called for below and return ..romptly. Your admission record will be ready when you arrive. While some of this information may seem unnecessary t.. 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 ava.. for your attending physician upon your arrival. Careful identification is necessary because it is not uncommon to have m.. records of different patients with the same names (including first names and middle initials) in our files. This form mu.. submitted 48 hours prior to the da.. of elective admission. (For outpatient/ambulatory cases, form must be submitted at lea.. hours 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 M F	CIVIL STATUS S M W D SEP	RELIGION

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

OCCUPATION	EMPLOYER	ADDRESS OF EMPLOYER – PHONE

ARE YOU A: ( ) VETERAN ( ) OFF ISLAND-STUDENT OTHERS SPECIFY

TRANSIENT: ( ) YES ( ) NO (IF YES EXPLAIN)

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 ( ) DEPENDENT ( ) FAMILY MEMBER ( ) COMPREHENSIVE COVERAGE ( )

OTHER HOSPITALIZATION INSURANCE COVERAGE

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

FORMS\PRE-ADMI.