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 seem unnecessary to you, it is needed by us to locate and identify any medical records of a former admission. It 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

~~FORMS/PRE-ADMI.~~

Please fax form to:
649-6494 on regular business hours (1st Floor Registration), or 648-6734 during afterhours (ED Registration Office).
Confirm receipt by calling 647-2238 (1st Floor), or 648-7904 (ED)