

PATIENT PRE-REGISTRATION FORM

Please complete as much of the following information as possible in order to expedite the pre-registration process.

I. PATIENT INFORMATION																		
Last Name			First Name			Middle Name			Maiden Name									
Street Address				Apt No.		City		State		Zip		County		Home Phone				
Birth Date		Birthplace (State)		Sex	Race	Social Security No.			Marital Status		Occupation							
Employer Name				Employer Address						Employer Phone								
Father's Name			Father's Birthplace (State)			Mother's Maiden Name			Mother's Birthplace (State)									
II. SPOUSE INFORMATION																		
Last Name			First Name			Middle Name			Street Address		Apt No.		City		State		Zip	
Home Phone		Social Security No.		Birth Date		Occupation				Employer Name								
Employer Address								Employer Phone										
III. GUARANTOR INFORMATION (Person responsible for payment of the account)																		
Relationship to Patient		Last Name			First Name			Middle Name			Birth Date		Social Security Number					
Street Address				Apt No.		City		State		Zip		Home Phone						
Occupation		Employer Name			Employer Address				Employer Phone									
IV. EMERGENCY CONTACT INFORMATION (Someone not residing in same household)																		
Relationship to Patient					Last Name			First Name			Middle Name							
Street Address				Apt No.		City		State		Zip		Home Phone		Work Phone				
V. INSURANCE INFORMATION (List all insurance plans you will be using to cover your hospital visit)																		
Name of Insurance Co. #1				Name of Policyholder				Relationship to Patient			Policy No.							
Insurance Company Address (Where to mail claim to)								Group No.										
Does the insurance require precertification?				Precertification phone # on card				Verification phone # on card										
Yes ___ No ___ (Look on insurance card)																		
Name of Insurance Co. #2			Name of Policyholder				Relationship to Patient			Policy No.								
Insurance Company Address (Where to mail claim to)						Group No.			Precertification Authorization #									
Does the insurance require precertification?				Precertification phone # on card				Verification phone # on card										
Yes ___ No ___ (Look on insurance card)																		
VI. MISCELLANEOUS INFORMATION																		
Primary Care Physician (PCP) name				PCP Phone Number		Referring Physician's Name				Referring Physician's Phone Number								
Test/Surgery/Admission Date		Reason for Test Surgery/Admission (Symptoms/Diagnosis)							Date Symptoms Began									
Religion		Room Preference (Admission Only) Private ___ Semi-Private ___				Have you been a patient here before? Yes ___ No ___				Date of Last Test/Admission								

Please remember that any amount not covered by insurance is due at time of dismissal. For preadmission financial counseling, please call 404-501-5157.