Admission or expected delivery date: _____ ***Name of obstetrician:*** _____

PRE-ADMISSION INFORMATION

Patient's Name: _____
Last *First* *Middle* *Maiden*

Address: _____

Home Phone: _____ Social Security Number: _____ Sex: ❑ Male ❑ Female

Date of Birth: _____ Race: _____ Ethnic: _____

Marital Status: ❑ single ❑ married ❑ separated ❑ divorced Spouse's Name: _____

Spouse's Date of Birth: _____ Age: _____ Spouse's Social Security Number: _____

Religious Preference: _____ May we release your religious preference? ❑ Yes ❑ No

In case of emergency, person to be notified: _____ Phone: _____

How related? _____ Cell Phone: _____

fold Address: _____

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

Pediatrician for Baby: _____ Phone: _____

If patient is a minor: Father's Date of Birth: _____ Mother's Date of Birth: _____

Please be advised if you are under the age of eighteen we will need to contact your legal guardian in order to get consent for treatment.

EMPLOYMENT

Patient's Employer: _____ Occupation: _____

Work Phone: _____ Work Address: _____

Spouse's Employer: _____ Occupation: _____

Work Phone: _____ Work Address: _____

Spouse's Date of Birth: _____ Age: _____ Spouse's Social Security Number: _____

INSURANCE

Name of ***Primary*** Insurance Company: _____ Phone: _____

fold Subscriber (Who is the insurance under?): _____

Insurance Company Address: _____

Name of Policy Holder: _____ ID / Subscriber / Member Number: _____

Group Number: _____ Type (PPO, HMO, etc.): _____

Name of ***Secondary*** Insurance Company: _____ Phone: _____

Subscriber (Who is the insurance under?): _____

Insurance Company Address: _____

Name of Policy Holder: _____ ID / Subscriber / Member Number: _____

Group Number: _____ Type (PPO, HMO, etc.): _____

Do you have prescription drug coverage? ❑ Yes ❑ No

Inpatient: Co payments will be requested at time of service.

COMMENTS

_____

_____

INSTRUCTIONS

If you receive this form five or more working days prior to your admission, please return through the mail.

If you receive the form less than five days prior to your admission, please bring it to the hospital when you check in.

•

Please bring your insurance card(s) and copay with you at the time of your admission.

•

For more information, please contact the Admitting Department at **(614) 293-8652.**

You can contact the Admitting Department 24 hours a day, seven days a week if you have any questions.

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PRE-ADMISSION INFORMATION FORM

The Ohio State University Medical Center