HANCOCK REGIONAL HOSPITAL PRE-ADMISSION

PATIENT NAME:____
(LAST) (FIRST) (MIDDLE)

MAIDEN NAME:_________________________ DATE OF BIRTH____________________

ADDRESS:____
(STREET ADDRESS, INCLUDE APARTMENT NUMBER IF APPLICABLE)

____
(CITY) (STATE) (ZIP)

TELEPHONE:_____________________ MARITAL STATUS: ______________________

SOCIAL SECURITY NUMBER:_________________________

REASON FOR VISIT: ____
(Type of testing)

PHYSICIAN ORDERING TESTING: ____

FAMILY PHYSICIAN:____

RELIGIOUS/CHURCH PREFERENCE:____

OB PATIENTS PLEASE COMPLETE THE FOLLOWING:

OB PHYSICIAN:________________________BABY'SPHYSICIAN:_____________________

ANTICIPATED DUE DATE:______________________________

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER NAME:____

EMPLOYER ADDRESS:____
(STREET) (CITY-STATE-ZIP)

ARE YOU COVERED WITH HEALTH INSURANCE THROUGH ABOVE EMPLOYER:__________
(YES OR NO)

IF YES:____
(INSURANCE COMPANY NAME) (POLICY-GROUP NUMBER)

____
(ADDRESS WHERE BILL IS TO BE SENT, PLEASE INCLUDE STREET,CITY,STATE,ZIP)

INSURANCE COMPANY TELEPHONE NUMBERS:____________________________________

DOES YOUR INSURANCE REQUIRE PRE-CERTIFICATION OR AUTHORIZATION? ________

NEAREST RELATIVE / OTHER INSURANCE INFORMATION

NEAREST RELATIVE NAME:____
(IF MARRIED PLEASE INDICATE SPOUSE'S FULL NAME)

NEAREST RELATIVE ADDRESS:____
(IF DIFFERENT THAN PATIENT) (STREET)

____
(CITY) (STATE) (ZIP) (TELEPHONE)

WHAT IS THE NEAREST RELATIVE'S RELATIONSHIP TO YOU?_____________________

IF MARRIED, SPOUSE'S EMPLOYER:____
(EMPLOYER NAME)

EMPLOYER ADDRESS:____
(STREET) (CITY-STATE-ZIP)

DOES SPOUSE CARRY HEALTH INSURANCE THAT COVERS YOU? ____________

____
(PLEASE BE SPECIFIC AS TO WHO IS COVERED, FAMILY, SPOUSE ONLY, ETC.)

IF APPLICABLE, INSURANCE COMPANY NAME:__________________________________

INSURANCE COMPANY ADDRESS:____
(STREET-CITY-STATE-ZIP)

INSURANCE COMPANY TELEPHONE NUMBERS:____________________________________

INSURANCE ID#:__________________________ GROUP/POLICY: _________________

SPOUSES SOCIAL SECURITY NUMBER:______________________________

SPOUSES DATE OF BIRTH:_______________________________________

ADDITIONAL INSURANCE INFORMATION:

MEDICARE : ____
(Medicare Number as it appears on the card)

MEDICAID:____
(Medicaid number as it appears on the card)

NAME AS IT APPEARS ON CARD:____________________________________

OTHER INSURANCE:____
(COMPANY NAME) (NAME OF INSURED PERSON)

____
(INSURANCE COMP.ADDRESS, INCLUDE STREET, CITY, STATE, ZIP.)

____
(INSURANCE COMP.TELEPHONE NUMBER) (GROUP/POLICY NUMBER)

____
(INSURED PERSONS ID NUMBER) (RELATIONSHIP TO PATIENT)

ADDITIONAL INFORMATION FOR OB PATIENTS:

WOULD YOU LIKE YOUR ADMISSION AND BIRTH OF BABY PRINTED IN THE LOCAL NEWSPAPERS?___________________________________
(YES OR NO)

IF NO, DO YOU WANT GENERAL INFORMATION RELEASED FROM OUR SWITCHBOARD AND INFORMATION DESK? ___________________________
(YES OR NO)

NOTE: GENERAL INFORMATION INCLUDES YOUR ROOM NUMBER AND TELEPHONE NUMBER IN YOUR ROOM AND IF YOU HAVE DELIVERED. WE DO NOT RELEASE THE SEX OF THE BABY AS WE FEEL THIS TAKES AWAY FROM THE PARENTS EXCITEMENT.

GENERAL HOSPITAL INFORMATION:

* YOUR TELEPHONE AND TELEVISION ARE AVAILABLE FOR YOUR USE AT NO ADDITIONAL COST.

* PLEASE USE THE MAIN ENTRANCE OF THE HOSPITAL WHEN ARRIVING FOR DELIVERY OR MONITORING. THIS ENTRANCE IS ACCESSIBLE 24 HOURS.

* **IT IS A HOSPITAL POLICY TO NOT TRANSFER CALLS TO THE OB DEPARTMENT CONCERNING PATIENTS IN LABOR. THIS TAKES OUR NURSING STAFF AWAY FROM THE PATIENT. PLEASE INSTRUCT FAMILY AND FRIENDS THAT WE CANNOT TRANSFER CALLS TO THE LABOR/DELIVERY ROOMS. IT WOULD BE BEST IF YOU CONTACT THESE INDIVIDUALS AFTER DELIVERY**

* PLEASE BRING ANY INSURANCE CLAIM FORM OR PRIOR AUTHORIZATION INFORMATION WITH YOU PRIOR TO OR AT THE TIME OF ADMISSION. IT IS VERY HELPFUL FOR THE HOSPITAL TO HAVE A PHOTO COPY OF YOUR INSURANCE CARD(S). YOU MAY STOP AT ANY REGISTRATION AREA TO PROVIDE THESE COPIES.

IF FINANCIAL ASSISTANCE OR ARRANGEMENTS ARE NEEDED, PLEASE CONTACT THE SOCIAL SERVICES DEPARTMENT AT (317) 468-4531 OR PATIENT BILLING AT (317) 468-4900 FROM 8:00 AM TO 4:00 PM MONDAY - FRIDAY

IF ADDITIONAL INFORMATION IS NEEDED, PLEASE CONTACT:

HANCOCK REGIONAL HOSPITAL: 462-5544 (MAIN NUMBER)
REGISTRATION DEPARTMENT : 468-4604 (ANSWERED 24 HOURS)
EDUCATION DEPARTMENT : 468-4506 (CLASS SCHEDULES)

FOR YOUR CONVENIENCE, COMPLETED FORMS MAY BE TURNED IN AT ANY REGISTRATION AREA, FAXED TO (317) 468-4161 OR MAILED TO:

HANCOCK REGIONAL HOSPITAL
P.O.BOX 827
GREENFIELD, IN 46140
ATTENTION: REGISTRATION DEPARTMENT, PRE-ADMISSION