

DUE DATE: _____

PATIENT INFORMATION

PATIENT'S NAME: <small>LAST</small> _____ <small>FIRST</small> _____ <small>MI</small> _____		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOC. SEC. NUMBER: _____		
DATE OF BIRTH: _____	AGE: _____	PLACE OF BIRTH (STATE): _____	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED <input type="checkbox"/> LEGALLY SEP.	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
MAILING ADDRESS: _____		CITY: _____	STATE: _____	ZIP CODE: _____	
HOME PHONE: _____					
MOTHER'S NAME: _____		FATHER'S NAME: _____			
RACE: _____	PRIMARY LANGUAGE: _____	EMPLOYMENT STATUS: <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED	<input type="checkbox"/> FULL TIME <input type="checkbox"/> STUDENT	DATE OF RETIREMENT: _____	
EMPLOYER/SCHOOL: _____	WORK PHONE: _____		EXT.: _____		
EMPLOYER'S ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____		
OCCUPATION: _____					

SPOUSE OR NEAREST LEGAL RELATIVE INFORMATION

RELATION: _____	NAME: <small>LAST</small> _____ <small>FIRST</small> _____				
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOC. SEC. NUMBER: _____	DATE OF BIRTH: _____	AGE: _____		
MAILING ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____		
COUNTY: _____	PHONE: _____	EMPLOYER/SCHOOL: _____			
EMPLOYER'S ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____		
WORK PHONE: _____	EXT.: _____	OCCUPATION: _____			

OTHER PERSON TO NOTIFY IN CASE OF AN EMERGENCY

RELATION: _____	NAME: <small>LAST</small> _____ <small>FIRST</small> _____				
MAILING ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____		
PHONE: _____	WORK PHONE: _____	EXT.: _____			

OTHER MISCELLANEOUS INFORMATION

ATTENDING PHYSICIAN: _____	PRIMARY CARE/OBGYN PHYSICIAN: _____	SURGERY SCHEDULED: _____			
ADVANCED DIRECTIVES: _____	DO YOU HAVE A HEALTH CARE PROXY? DO YOU HAVE A LIVING WILL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YOU WERE A PREVIOUS HIGHLAND PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LAST ADMIT: _____		
PREVIOUS NAME: _____	VETERAN: <input type="checkbox"/> YES <input type="checkbox"/> NO				
CHURCH OR PARISH: _____	RELIGION: _____	ROOM PREFERENCE: <input type="checkbox"/> PRIVATE <input type="checkbox"/> SEMI-PRIVATE <small>(FOR OVERNIGHT STAYS)</small>	EXPECTED DATE OF ADMISSION: _____		

FOR MATERNITY ADMISSION ONLY

PEDIATRICIAN: _____	FATHER'S NAME/INFORMATION (if different): _____	FATHER'S DATE OF BIRTH: _____			
SOC. SEC. NUMBER: _____	ADDRESS: _____	CITY: _____	STATE: _____	ZIP: _____	

FOR OFFICE USE ONLY

MOTHER CASE NO.: _____	ADMIT TIME: _____	NEWBORN SEX: _____	CASE NO.: _____	BIRTH WEIGHT: _____		
ADMIT DATE: _____	ROOM NO.: _____	FIN. CL.: _____	M: _____ B: _____	DATE: _____	TIME: _____	CRIB NO.: _____

NOTE: BRING YOUR INSURANCE CARD WITH YOU

INSURANCE INFORMATION (IF COVERED UNDER MULTIPLE INSURANCE PLANS, PLEASE LIST ALL INFORMATION)

BLUE CROSS OR HMO PLANS	<input type="checkbox"/> BLUE CROSS <input type="checkbox"/> BLUE CHOICE <input type="checkbox"/> PREFERRED CARE OPTION <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> PREFERRED CARE <input type="checkbox"/> BLUE CHOICE OPTION <input type="checkbox"/> PREFERRED CARE GOLD <input type="checkbox"/> STRONG CARE <input type="checkbox"/> BLUE CHOICE SENIOR			
	NAME OF SUBSCRIBER/MEMBER/POLICY HOLDER:			IS PRE-ADMISSION CERTIFICATION REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO
	CONTRACT #/MEMBER ID# (INCLUDE ALL LETTERS/#'S):			
	EFFECTIVE DATE:		GROUP #:	
NAME & ADDRESS OF BLUE CROSS PLAN (IF NOT IN ROCHESTER):				
	NAME (AS IT APPEARS ON MEDICARE CARD)		HEALTH INS. CLAIM #:	
	HAVE YOU BEEN ADMITTED TO A HOSPITAL WITHIN THE PAST YEAR: <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DATE(S) OF ADMIT:	
	NAME OF HOSPITAL(S):			
MEDICARE	IS YOUR SPOUSE EMPLOYED: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, ARE YOU COVERED UNDER YOUR SPOUSE'S INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO		
	IF YES, SPOUSE'S NAME:		EMPLOYER:	
	INSURANCE NAME:		CONTRACT #:	
	ADDRESS OF INSURANCE:			EFFECTIVE DATE:
MEDICAID	CIN #/RECIPIENT NUMBER:		EFFECTIVE DATE:	COUNTY:
COMMERCIAL INS. / MOTOR VEHICLE ACCIDENT / OTHER INS.	INSURANCE COMPANY NAME:			PHONE NUMBER: ()
	ADDRESS:		CITY:	STATE: ZIP:
	NAME OF INSURED:		POLICY #/WCB#/CARRIER CASE:	
	INSURED EMPLOYER:		IS PRE-ADMISSION CERTIFICATION REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
	EMPLOYER ADDRESS:		CITY:	STATE: ZIP:
DATE OF ACCIDENT OR INJURY:		LOCATION:		
	MOTOR VEHICLE INSURANCE COMPANY NAME:			
	ADDRESS:		CITY:	STATE: ZIP:
FOR CHILD UNDER 18	MOTHER'S DATE OF BIRTH:		FATHER'S DATE OF BIRTH:	

HOW WERE YOU FIRST INTRODUCED TO HIGHLAND HOSPITAL?

- BREAST CARE CENTER FAMILY TIES (BABY CLUB) SENIOR HEALTHSOURCE OTHER _____
 DIABETES HEALTHSOURCE NEED-A-PHYSICIAN WOMEN'S HEALTHSOURCE

WE WILL MAKE EVERY EFFORT TO PROVIDE THE ACCOMMODATION OF YOUR CHOICE. HOWEVER, ROOMS ARE ASSIGNED THE DAY OF ADMISSION AND DUE TO UNFORESEEN SHORTAGES OF BEDS, WE CANNOT GUARANTEE IN ADVANCE THAT YOU WILL RECEIVE THE ACCOMMODATION YOU PREFER. IF YOU HAVE REQUESTED A SEMI-PRIVATE ROOM AND NONE IS AVAILABLE THE DAY OF YOUR ADMISSION, WE WILL ASSIGN YOU TO A PRIVATE ROOM. THE ADDITIONAL CHARGE FOR A PRIVATE ROOM IS NOT COVERED BY MOST INSURANCE PLANS, THEREFORE YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. IF YOU HAVE ANY QUESTIONS PLEASE CALL THE BUSINESS OFFICE AT 461-6857.

SIGNATURE OF PERSON COMPLETING FORM _____

DATE _____

CHECK FORM FOR COMPLETENESS AND RETURN AT YOUR EARLIEST CONVENIENCE