HIGHLAND HOSPITAL | An Affiliate of the University of Rochester Medical Center

MEDICINE of the HIGHEST ORDER

1000 SOUTH AVE. • ROCHESTER, NY 14620 • (585) 473-2200

PLEASE ANSWER ALL QUESTIONS ON THE FRONT/BACK OF THIS FORM.
SURGICAL PATIENTS – BRING IN WITH YOU AT PRE-SURGICAL SCREENING
MATERNITY PATIENTS – RETURN IMMEDIATELY – ENCLOSED ENVELOPE

☐ SURGICAL PRE-ADMISSION

☐ MATERNITY PRE-ADMISSION

EXPECTED DUE DATE: _____

SURGICAL / MATERNITY PATIENT INFORMATION

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

SPOUSE OR LEGAL RELATIVE INFORMATION FOR EMERGENCY CONTACT

RELATION:	NAME: LAST FIRST		
SEX: ☐ MALE ☐ FEMALE	SOC. SEC. NUMBER:	DATE OF BIRTH:	AGE:
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
COUNTY:	HOME PHONE: / CELL PHONE:	EMPLOYER/ SCHOOL: / FT/PT	
EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP CODE:
WORK PHONE:	EXT.:	OCCUPATION:	

NEXT PERSON TO NOTIFY IN CASE OF AN EMERGENCY

RELATION:	NAME: LAST FIRST		
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:	EXT.:

OTHER MISCELLANEOUS INFORMATION

SURGEON: (or) OR/GYN PHYSICIAN:	PRIMARY CARE PHYSICIAN (PCP)		DATE SURGERY/ADMISSION SCHEDULED:
ADVANCED DIRECTIVES: DO YOU HAVE A HEALTH CARE PROXY? ☐ YES ☐ NO DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO		IF YOU WERE A PREVIOUS HIGHLAND PATIENT ➤	DATE OF LAST ADMIT:
PREVIOUS NAME:			VETERAN: ☐ YES ☐ NO
CHURCH OR PARISH:	RELIGION:	CLERGY TO BE NOTIFIED ☐ YES ☐ NO	ROOM PREFERENCE: (FOR OVERNIGHT STAYS) ☐ PRIVATE ☐ SEMI-PRIVATE

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 LOCAL/ROCHESTER
- ☐ BLUE CROSS OUT OF AREA
- ☐ BLUE CHOICE
- ☐ BLUE CHOICE OPTION
- ☐ BLUE CHOICE SENIOR
- ☐ MEDICARE BLUE CHOICE
- ☐ FAMILY HEALTH PLUS
- ☐ PREFERRED CARE MVP
- ☐ PREFERRED GOLD MVP
- ☐ PREFERRED OPTION MVP
- ☐ PREFERRED OPTION FAMILY MVP
- ☐ MEDICARE
- ☐ MEDICAID
- ☐ MOTOR VEHICLE
- ☐ WORKERS COMP
- ☐ OTHER (LIST NAME): _____

PRIMARY INSURANCE

NAME OF SUBSCRIBER/ MEMBER/POLICY HOLDER:	SUBSCRIBER DATE OF BIRTH:	IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
CONTRACT #/MEMBER ID # **(INCLUDE ALL LETTERS/#'S):**		
EFFECTIVE DATE:	GROUP #:	NAME OF INSURANCE:
ADDRESS OF INSURANCE PLAN:		

SECONDARY INSURANCE

NAME OF SUBSCRIBER/ MEMBER/POLICY HOLDER:	SUBSCRIBER DATE OF BIRTH:	IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
CONTRACT #/MEMBER ID # **(INCLUDE ALL LETTERS/#'S):**		
EFFECTIVE DATE:	GROUP #:	NAME OF INSURANCE:
ADDRESS OF INSURANCE PLAN:		

MEDICAID

CIN #/RECIPIENT NUMBER:	EFFECTIVE DATE:	COUNTY:

FOR TREATMENT RELATED TO MOTOR VEHICLE ACCIDENT/WORKERS COMP

INSURANCE COMPANY NAME:			PHONE NUMBER: ( )
ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURED:	POLICY #/WCB #/ CARRIER CASE:		IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
INSURED EMPLOYER:			
EMPLOYER ADDRESS:	CITY:	STATE:	ZIP:
DATE OF ACCIDENT OR INJURY:	LOCATION:		
MOTOR VEHICLE INSURANCE COMPANY NAME:			
ADDRESS:	CITY:	STATE:	ZIP:

HOW WERE YOU FIRST INTRODUCED TO HIGHLAND HOSPITAL?

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

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 (585) 341-6536.

_____ SIGNATURE OF PERSON COMPLETING FORM

_____ DATE

PLEASE CHECK FORM FOR COMPLETENESS
SURGICAL PATIENTS – BRING IN AT PRE-SURGICAL SCREENING
MATERNITY PATIENTS – RETURN COMPLETED FORM IN ENCLOSED ENVELOPE