

Memorial Hospital of South Bend*

Pre-Admission Form

Please fill out the following information and return this form as soon as possible for general admissions. If this is a **maternity admission**, return the form **3 months** prior to your due date.

For Office Use Only

Diagnosis _____
 Department _____
 ICD-9 _____

Room Preference: *Every effort will be made to assign you to the type of room requested.*

Semi-Private Private Maternity

Admitting Physician: _____

Inpatient Outpatient

Expected Date of Admission/Delivery: ____/____/____

Attending Physician: _____

Pediatrician will be: Dr. _____

Please print or type: Fill in all of the spaces below

Patient Information										
Patient's Last Name (<i>as it appears on the insurance policy</i>)			First Name		Initial		Previous		Telephone	Social Security Number
Street Address (Box No., Apt., Etc.)			City		State		Zip	Age	Birthdate	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
_S _M _W _D	Marital Status		Religion		Church/Synagogue (<i>name & city</i>)					<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Admissions (<i>Nursing Home or Hospital</i>)			Where		Date					Your Name at That Time
Patient's Employer			Address				Telephone			
Race: <input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Am. Indiana/Alaskan native	<input type="checkbox"/> Other					
In Case of an Emergency Please Notify										
Name			Address, City & State			Zip		Telephone		Relationship
Insurance Information										
Insurance/HMO	1st	Employer		Employer's Address				Telephone		
		Employee's Name		Date of Birth	Relationship to Patient		Insurance Co. Name, Address & Telephone			
		Policy Number		Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Coverage	Policyholder's S.S.#			
	2nd	Employer		Employer's Address				Telephone		
		Employee's Name		Date of Birth	Relationship to Patient		Insurance Co. Name, Address & Telephone			
		Policy Number		Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Coverage	Policyholder's S.S.#			
Champus	Name of Sponsor		Active Duty-Military Station Address				Non-availability form obtained <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Rank/Grade	Service Branch	Sponsor's SS#		Status	Dep.ID#	Eff. Date	Exp. Date		

Is your admission the result of any type of accident? Yes No Date of Accident: _____

Have you applied for any type of assistance? Yes No **What type of assistance?** _____

Policyholder's Signature

_____/_____/_____
Date

Patient's Signature if not Policyholder

_____/_____/_____
Date