



This form is to be completed either by the patient or his/her guardian.

REGISTRATION / ADMISSION WORKSHEET

YOUR ADMITTING DOCTOR _____ ADMISSION DATE _____

TYPE OF ADMISSION: Short Stay Outpatient Inpatient OB LMP Date: _____

FOR OFFICE USE ONLY

Acct # _____ Med Rec# _____

PLEASE CHECK THE CORRECT ANSWER, OR FILL IN THE BLANKS AS COMPLETELY AS POSSIBLE

Name (Last, First, MI): _____

Maiden or other names used: _____

Local (Mailing) Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different from above): _____

City: _____ State: _____ Zip: _____

Are You a Veteran? Yes Do you want to apply for VA benefits at this time? Yes
If yes, answer the questions below.

Date of military service: _____ Branch of service: _____

Do you have a service-connected VET illness or injury? Yes Claim # _____

Sex Male Female Birthdate: _____ Birthplace: _____ Age _____

Marital Status (Check one):

- S Single
- W Widowed
- M Married
- X Separated
- D Divorced
- U Not applicable

Religion (Check one):

- AD Adventist
- BD Buddhist
- BP Baptist
- CA Catholic
- CH Christian
- EP Episcopalian
- JE Jewish
- JW Jehovah Witness
- LU Lutheran
- ME Methodist
- MO Mormon (LDS)
- NO None
- OX Other
- PN Pentecostal
- PR Presbyterian
- PS Protestant
- XX Unknown

Race (Check one):

- A American Indian / Eskimo
- B Black
- C Chinese
- F Filipino
- H Hawaiian
- J Japanese
- K Korean
- O Other Asian Pacific Islander
- P Part Hawaiian
- Q Hispanic
- S Polynesian
- W Caucasian
- X Other

Check here if you want your name withheld from the religious list.

Have you assigned anyone to be a Durable Power of Attorney for your health care? Yes No

If yes, Name of Durable Power of Attorney: _____ Relationship _____

Address _____ Phone _____

Do you have a Medical Living Will? Yes No

If you have these documents, bring them to the Hospital and inform the Admitting Office or Nursing staff.

Check here if you want your name and location withheld from the public.

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT OF THE HOSPITAL BILL)
(If the patient is a minor, parent or adult must be the guarantor)

Name: _____ Relationship to patient: _____

Guarantor's Employment Status:

F <input type="checkbox"/> Full time	Occupation: _____
M <input type="checkbox"/> Active military	Employer: _____
D <input type="checkbox"/> Disabled	Employer address: _____ phone: _____
P <input type="checkbox"/> Part time	_____
R <input type="checkbox"/> Retired	Guarantor address: _____ phone: _____
N <input type="checkbox"/> Not known	_____
S <input type="checkbox"/> Self-employed	Guarantor Social Security Number: _____
U <input type="checkbox"/> Unemployed	Guarantor Birthdate: _____

Spouse's Name _____

Spouse's Address _____ Phone _____

Nearest Relative Name _____

Relative's Address _____ Home Phone _____

Business Phone _____

In case of Emergency, contact _____ Relationship _____

Contact's Address _____ Home Phone _____

Business Phone _____

**Patient's Father's Name _____

**Patient's Mother's Name _____

** Only required for minor patients

This section is for AUTO ACCIDENT, WORKER'S COMPENSATION OR OTHER ACCIDENTS

Is this hospitalization accident-related? Yes No

If yes, date of accident or injury: _____

Time of accident or injury: _____

Where did the accident or injury occur? _____

IF WORKER'S COMPENSATION CASE:

Employer at time of injury _____

Business address _____

Business phone _____ Insurance Company _____

INSURANCE INFORMATION

Company:	Subscriber Employment Status:
Membership Number:	F <input type="checkbox"/> Full time
Group Number:	P <input type="checkbox"/> Part time
Plan/Medical coverage Code:	M <input type="checkbox"/> Active military
Subscriber Name:	S <input type="checkbox"/> Self-employed
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	R <input type="checkbox"/> Retired
Relationship to patient:	U <input type="checkbox"/> Unemployed
Subscriber Address:	N <input type="checkbox"/> Unknown
	D <input type="checkbox"/> Disabled
Subscriber Phone Number:	Employer:
Subscriber Social Security Number:	Employer Address:
Subscriber Birthdate:	Employer Phone:

Company:	Subscriber Employment Status:
Membership Number:	F <input type="checkbox"/> Full time
Group Number:	P <input type="checkbox"/> Part time
Plan/Medical coverage Code:	M <input type="checkbox"/> Active military
Subscriber Name:	S <input type="checkbox"/> Self-employed
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	R <input type="checkbox"/> Retired
Relationship to patient:	U <input type="checkbox"/> Unemployed
Subscriber Address:	N <input type="checkbox"/> Unknown
	D <input type="checkbox"/> Disabled
Subscriber Phone Number:	Employer:
Subscriber Social Security Number:	Employer Address:
Subscriber Birthdate:	Employer Phone:

Company:	Subscriber Employment Status:
Membership Number:	F <input type="checkbox"/> Full time
Group Number:	P <input type="checkbox"/> Part time
Plan/Medical coverage Code:	M <input type="checkbox"/> Active military
Subscriber Name:	S <input type="checkbox"/> Self-employed
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	R <input type="checkbox"/> Retired
Relationship to patient:	U <input type="checkbox"/> Unemployed
Subscriber Address:	N <input type="checkbox"/> Unknown
	D <input type="checkbox"/> Disabled
Subscriber Phone Number:	Employer:
Subscriber Social Security Number:	Employer Address:
Subscriber Birthdate:	Employer Phone: