

**PLEASE ANSWER ALL  
 QUESTIONS ON FRONT  
 AND BACK AND RETURN  
 IMMEDIATELY.**

SURGICAL PRE-ADMISSION  
 MATERNITY PRE-ADMISSION

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:		COUNTY:				
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 LEGAL RELATIVE INFORMATION FOR EMERGENCY CONTACT**

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:	FT/PT		
EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP CODE:		
WORK PHONE:	EXT.:	OCCUPATION:			

**NEXT 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**

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

**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)**

<input type="checkbox"/> BLUE CROSS LOCAL/ROCHESTER	<input type="checkbox"/> PREFERRED CARE	<input type="checkbox"/> MEDICARE
<input type="checkbox"/> BLUE CROSS OUT OF AREA	<input type="checkbox"/> PREFERRED CARE GOLD	<input type="checkbox"/> MEDICAID
<input type="checkbox"/> BLUE CHOICE	<input type="checkbox"/> PREFERRED CARE OPTION	<input type="checkbox"/> MOTOR VEHICLE
<input type="checkbox"/> BLUE CHOICE OPTION		<input type="checkbox"/> WORKERS COMP
<input type="checkbox"/> BLUE CHOICE SENIOR		<input type="checkbox"/> OTHER (LIST NAME): _____
<input type="checkbox"/> MEDICARE BLUE CHOICE		
<input type="checkbox"/> FAMILY HEALTH PLUS		

**PRIMARY INSURANCE**

NAME OF SUBSCRIBER/ MEMBER/POLICY HOLDER:		SUBSCRIBER DATE OF BIRTH:	IS PRE-ADMISSION CERTIFICATION REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> 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:
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**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: <input type="checkbox"/> YES <input type="checkbox"/> NO
INSURED EMPLOYER:	EMPLOYER ADDRESS:		
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   
  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 341-6857.

\_\_\_\_\_  
SIGNATURE OF PERSON COMPLETING FORM

\_\_\_\_\_  
DATE

**CHECK FORM FOR COMPLETENESS AND RETURN AT YOUR EARLIEST CONVENIENCE**