AdventHealth Ottawa

SURGICAL PRE-ADMISSION PATIENT REGISTRATION FORM

VISIT INFORMATION

Physician Performing Procedure: _____Date of Service: _____

Procedure Being Done: _____ Primary Care Physician: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security #: _____ Email: _____

MAILING ADDRESS INFORMATION

Street/PO BOX: _____ Apt #: _____ Home Phone #: _____

Cell Phone #: _____City: _____ State: _____ Zip Code: _____

PERSONAL INFORMATION

Sex: ❑M ❑F Race: _____ Preferred Language: _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widow ❑Separated Ethnicity: ❑Hispanic ❑Not Hispanic

Smoking Status: ❑Current Every Day ❑Current Some Day ❑Former ❑Never ❑Heavy ❑Light

Do you have a Living Will? ❑Yes ❑No Do you have a Durable Power of Attorney? ❑Yes ❑No

If yes, is it on file with Ransom Memorial Hospital? ❑Yes ❑No

EMPLOYMENT INFORMATION

Employer: _____Occupation: _____ Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT / SPOUSE INFORMATION

Name: _____ Relationship: _____

Home Phone #: _____Cell Phone #: _____ Work Phone #: _____

GUARANTOR INFORMATION (If patient is a minor or if anyone other than the patient is the bill to)

Name: _____ Relationship: _____ Sex: ❑M ❑F

Street/PO BOX: _____ Apt #: _____ Home Phone #: _____

Cell Phone #: _____City: _____ State: _____ Zip Code: _____

Is the reason for your visit due to a workman's compensation or auto accident? ❑Yes ❑No

If you answered **YES**, please fill out parts **A & B**

If you answered **NO**, please fill out **only part A**

PART A

Are you 65 years of age or older? ❑Yes ❑No Retirement Date: _____

Are you disabled? ❑Yes ❑No

Do you have End Stage Renal Disease? ❑Yes ❑No Start Date of Dialysis: _____

PRIMARY INSURANCE

Subscriber Name: _____ Date of Birth: _____ Sex: ❑M ❑F

Address:_____ Relationship to Patient: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

SECONDARY INSURANCE

Subscriber Name: _____ Date of Birth: _____ Sex: ❑M ❑F

Address:_____ Relationship to Patient: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

TERTIARY INSURANCE

Subscriber Name: _____ Date of Birth: _____ Sex: ❑M ❑F

Address:_____ Relationship to Patient: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

PART B

WORKER'S COMPENSATION

Date of Accident: _____ Location of Accident: _____

Name of Employer (at time of accident):_____

Contact Person: _____ Contact Phone #: _____

Name of Insurance Company:_____

Claim #: _____ Adjustor Name: _____ Phone #: _____

AUTO ACCIDENT

Date of Accident: _____ Location of Accident: _____

Name of Insurance Company:_____

Policy #: _____ Claim #: _____

Adjustor Name: _____Adjustor Phone #: _____