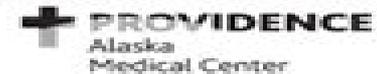


PROVIDENCE HOSPITAL
PRE-ADMISSION FORM



PO BOX 10000 • ANCHORAGE, ALASKA 99510-9904
 PHONE (907) 942-0111

THE COMMITMENT CONTINUES

| PROCEDURE INFORMATION - REQUIRED FOR REGISTRATION | | | |
|---|---------------------|--|--|
| WHAT TYPE OF SERVICE ARE YOU REGISTERING FOR? <input type="checkbox"/> MATERNITY <input type="checkbox"/> DAY SURGERY <input type="checkbox"/> GENERAL SURGERY <input type="checkbox"/> OTHER: | | FACILITY DIRECTORY <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DIAGNOSIS/SYMPTOMS: | | DATE OF ONSET | |
| EXPECTED DATE OF ADMISSION | ADMITTING PHYSICIAN | IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD | |

PATIENT INFORMATION

| | | | | | | | |
|---|------------|------------------------|-----------|------------------------|---|--------------------|--|
| PATIENT NAME: Last First MI | | | | | | PREVIOUS NAME | |
| SEX | BIRTH DATE | SOCIAL SECURITY NUMBER | WVA STATE | RACE | RELIGION | CHURCH AFFILIATION | |
| PATIENT MAILING ADDRESS: City State Zip | | | | POSSESS ADV DIRECTIVE? | IF YES, WHERE IS COPY KEPT? <input type="checkbox"/> PROVIDENCE | | |
| HOME PHONE | | EMPLOYER | | OTHER: WORK PHONE | | OCCUPATION | |

RESPONSIBLE PARTY (IF OTHER THAN THE PATIENT) FOLD HERE

| | | | | |
|-------------------------|--|---------------|-----|------------------------|
| LAST NAME: FIRST MI | | DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER |
| ADDRESS: City State Zip | | HOME PHONE | | WORK PHONE |

EMERGENCY CONTACT

| | | | | |
|--|---|------------|------------|--|
| LAST NAME: FIRST MI | | HOME PHONE | WORK PHONE | REL. TO PATIENT |
| NAME YOU EVER BEEN IN THE MILITARY? ARE YOU USING YOUR VA MEDICAL BENEFITS? <small>If yes, then you must complete a VA 1010.</small> | | YES | NO | ARE YOU ELIGIBLE FOR ALASKA NATIVE BENEFITS AT AHS HOSPITAL? |
| | | YES | NO | YES |
| | | YES | NO | ARE YOU A U.S. CITIZEN? |
| | | YES | NO | YES |
| SELF PROP? | WOMAN'S COMPENSATION? <small>(If yes, please complete next four blocks.)</small> | YES | NO | WOMAN'S COMP CARRIER |
| YES | | YES | | DATE OF INJURY |
| NO | | NO | | CLAIM NUMBER |

INSURANCE 1 — REMEMBER TO PRE-AUTHORIZE WITH YOUR INSURANCE COMPANY! — INCLUDE MEDICAID INFORMATION

| | | | | | |
|----------------------------------|-----------------------|---|---------------------|-------------------------------|-----------------|
| PRIMARY INSURANCE NAME | | PRIMARY INSURANCE ADDRESS: City State Zip | | | |
| SUBSCRIBER NAME (Insured Person) | SUBSCRIBER NUMBER | GROUP NUMBER | SUB. SEX F M | EMPLOYMENT STATUS (Check One) | |
| SUBSCRIBER EMPLOYER | SUBSCRIBER WORK PHONE | SUBSCRIBER DATE OF BIRTH | HOW RELATED TO P/L? | AUTHORIZATION #? | |
| | | | | Full Time | Part Time |
| | | | | Self Employed | Retired |
| | | | | Not Employed | Active Military |

INSURANCE 2 FOLD HERE

| | | | | | |
|----------------------------------|-----------------------|---|---------------------|-------------------------------|-----------------|
| PRIMARY INSURANCE NAME | | PRIMARY INSURANCE ADDRESS: City State Zip | | | |
| SUBSCRIBER NAME (Insured Person) | SUBSCRIBER NUMBER | GROUP NUMBER | SUB. SEX F M | EMPLOYMENT STATUS (Check One) | |
| SUBSCRIBER EMPLOYER | SUBSCRIBER WORK PHONE | SUBSCRIBER DATE OF BIRTH | HOW RELATED TO P/L? | AUTHORIZATION #? | |
| | | | | Full Time | Part Time |
| | | | | Self Employed | Retired |
| | | | | Not Employed | Active Military |

INSURANCE 3

| | | | | | |
|----------------------------------|-----------------------|---|---------------------|-------------------------------|-----------------|
| PRIMARY INSURANCE NAME | | PRIMARY INSURANCE ADDRESS: City State Zip | | | |
| SUBSCRIBER NAME (Insured Person) | SUBSCRIBER NUMBER | GROUP NUMBER | SUB. SEX F M | EMPLOYMENT STATUS (Check One) | |
| SUBSCRIBER EMPLOYER | SUBSCRIBER WORK PHONE | SUBSCRIBER DATE OF BIRTH | HOW RELATED TO P/L? | AUTHORIZATION #? | |
| | | | | Full Time | Part Time |
| | | | | Self Employed | Retired |
| | | | | Not Employed | Active Military |

Fold and Seal

Fake Miscarriage Documents

SJ Ball



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