

PRE-REGISTRATION INFORMATION

Pre-Registration Phone Number: (941) 917-7322

1700 S. Tamiami Trail, Sarasota Florida 34239

Anticipated Admission/ Service Date: _____

(If Pregnant) Due Date: _____

Admitting Physician: _____

This form will assist us in preparing for your upcoming inpatient/outpatient visit. If your visit is less than 7 days away, one of our Registration Representatives will be calling to collect the information over the phone. So, you may want to have this necessary information handy. If you are pregnant or if your scheduled visit is more than 7 days away, you may mail this form to us at the above address.

PERSONAL INFORMATION

PATIENT INFORMATION:

Name (Last, First, Middle): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Local Address (if different): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

County of Residence: _____ Since: _____

Social Security Number: _____

Sex: Male Female Race: _____ Date of Birth: _____ Place of Birth: _____

Marital Status: Single Married Divorced Widowed Separated

Have you ever been a patient at Sarasota Memorial Hospital before? Yes No

Most recent hospital or Skilled Nursing Facility admission: From _____ to _____

Religious Preference: _____

Church: _____

Would you like your clergyman to visit you while you are in the Hospital? Yes No

Would you like a hospital Chaplain to visit you while you are in the Hospital? Yes No

SPOUSE / NEAREST RELATIVE INFORMATION:

Spouse Name (Last, First, Middle): _____

Spouse's Date of Birth: _____ Spouse's Social Security Number: _____

Nearest Relative/Emergency Contact

Other than Spouse (Last, First, Middle): _____

Address: _____

Relationship: _____ Phone: _____

FINANCIAL INFORMATION

EMPLOYMENT:

PATIENT'S EMPLOYMENT INFORMATION – *If patient is a minor, list financially responsible person's employment information*

Name (Last, First, Middle): _____

Relationship to Patient: _____

Employment Status: Full Time Part Time Self-Employed Retired

Name of Employer (If retired, from where): _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employed/Retired Since: _____ Employer's Phone: _____

Occupation/Title: _____

SECONDARY EMPLOYMENT INFORMATION: – *Patient's spouse or other parent if patient is a minor*

Name (Last, First, Middle): _____

Relationship to Patient: _____

Employment Status: Full Time Part Time Self-Employed Retired

Name of Employer (If retired, from where): _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employed/Retired Since: _____ Employer's Phone: _____

Occupation/Title: _____

Sarasota Memorial Health Care System is a NON-SMOKING facility

INSURANCE INFORMATION

Please bring a picture I.D., insurance cards, and any forms required by your insurance company. If you prefer, include with this questionnaire a copy of both the front and back of your I.D., insurance cards and/or forms.

Is this Service related to:

Employment Accident Yes No
Automobile Accident Yes No
Other Type of Accident. Yes No

If other type of accident, give a brief explanation: _____

Date of Accident: _____ Approximate Time of Accident: _____ AM PM

Place of Accident: _____

PRIMARY INSURANCE CARRIER:

If applicable, please list patient's: Medicare #: _____
Medicaid #: _____

Otherwise, complete the following:

Insured's Name (Last, First, Middle): _____

Insured's Birth Date: _____ Insured's Social Security #: _____

Name of Insurance Company (If Blue Cross, list state and plan code): _____

Insurance Company Address: _____

Policy I.D. Number(s): _____

Name and Telephone Number of Employer or Insurance Agent that coverage is purchased through:

If through Employer, Group Number: _____

SECONDARY INSURANCE CARRIER:

Insured's Name (Last, First, Middle): _____

Insured's Birth Date: _____ Insured's Social Security #: _____

Name of Insurance Company (If Blue Cross, list state and plan code): _____

Insurance Company Address: _____

Policy I.D. Number(s): _____

Name and Telephone Number of Employer or Insurance Agent that coverage is purchased through:

If through Employer, Group Number: _____

If Patient is a dependent over 18, is He/She attending college as a student? Yes No

If Yes, Name of School: _____ Full Time Part Time Day Evening

Veteran Status: Veteran – No Yes – Veteran's Number: _____

Disability with Service: Yes No

Note: If pre-admission authorization/certification is required for this admission by your carrier, be sure your physician has contacted your carrier. All surgery patients should ask their insurance carrier if second surgical opinions are required prior to admission and make necessary arrangements. If additional insurance is available, please list the appropriate information on a separate sheet of paper and return it with this form.

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