

PRE-REGISTRATION INFORMATION

Pre-Registration Phone Number: (941) 917-6775 1700 S. Tamiami Trail, Sarasota Florida 34239

Anticipated Admission Date:
(If Pregnant) Due Date:
Admitting Physician:

This form will assist us in preparing for your upcoming hospital 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: _____

MISCELLANEOUS:

Do you have a Sarasota Memorial Hospital Courtesy Card? Yes No

If yes, Number: _____ In whose name? _____

Room preference, *if available* Private Semi-Private

Sarasota Memorial Hospital is a NON-SMOKING facility

INSURANCE INFORMATION

Please bring a picture I.D., insurance cards, and any forms required by your insurance company, with you on the day of admission. 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 Admission 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 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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