



PRE-ADMISSION FORM

PLEASE RETURN THIS FORM WITHIN TWO DAYS IN THE SELF-ADDRESSED ENVELOPE PROVIDED, OR FAX TO 650-347-6201.

Dr. _____ HAS SCHEDULED YOUR PROCEDURE ON _____

Name: Last _____ First _____ Middle _____ Social security number _____

Primary Care Physician _____ Religion _____ Chaplain visit? Yes No

Birthdate _____ Age _____ Sex _____ Marital status Single Divorced Separated Married Widowed Do you use tobacco products? Yes No

Date of previous visit/admission to our facility and name at time of admission _____

Where hospitalized past 12 months and dates _____

Patient address - street _____ City _____ State _____ Zip code _____ Phone _____ Alternate phone _____

Patient employer/address _____ Occupation _____ Phone _____

Name of spouse/partner or next of kin and address _____ Phone _____ Alternate phone _____ Relationship _____

Spouse/partner/next of kin employer/address _____ Occupation _____ Phone _____

Notify in emergency - name and address _____ Phone _____ Alternate phone _____ Relationship _____

Race (check one) - The hospital is required by law to report this information to the state for health planning purposes

1 White 2 Black 3 Native American/Eskimo/Aleut 4 Asian/Pacific Islander 5 Other _____ 6 Unknown

Is your ethnic origin Hispanic? Yes No Unknown Do you have an Advance Directive/Power of Attorney for health care decisions? Yes No

If yes, please bring a copy for our records

Primary Health Plan				Secondary Health Plan			
Name of insured as shown on card		Relationship to patient		Name of insured as shown on card		Relationship to patient	
Address		Phone		Address		Phone	
City		State	Zip code	City		State	Zip code
Health plan				Health plan			
Group name				Group name			
ID #	Group #	Through employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		ID #	Group #	Through employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Health plan billing address				Health plan billing address			
Customer service phone #		Pre-certification #		Customer service phone #		Pre-certification #	

Is this admission covered by a worker's compensation claim? Yes No

Name of insurance _____ Adjustor name _____

Claim number _____ Phone _____

Date of injury _____ Employer at time of injury _____

Do you need assistance due to: Visual impairment Yes No
Hearing impairment Yes No

Interpreter required? Yes No Primary language _____ American Sign Language? _____

Once this form is received by us, you will be called to schedule a pre-admission testing appointment.