



PRE-ADMISSION FORM

PLEASE RETURN THIS FORM WITHIN TWO DAYS IN THE SELF-ADDRESSED ENVELOPE PROVIDED, OR FAX TO 650-696-5366.

Dr. _____ HAS SCHEDULED YOUR ADMISSION ON _____

Name: Last		First		Middle		Social security number	
Primary Care Physician						Religion	
						Chaplain visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate	Age	Sex	Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Unknown 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.