Lourdes Medical Center Pre-Admission Form

Patient Information:

Patient Name: ______________________ DOB: __________

(Last) (First) (Middle)

Family Physician: __________

Social Security Number: __________ Marital Status __________ Religion: __________

Address,City,St,Zip ______________________

Phone (H): __________ Phone (C): __________ Prf. Time __________

Maiden Name: __________ Mother's Name __________ Sex: M F

Patient Employer: __________ Address/Phone# __________

Emergency Contact: __________ Phone # __________ Relationship __________

Emergency Contact: __________ Phone # __________ Relationship __________

Guarantor Information:

Guarantor Name: __________ Relationship: __________

Guarantor Address,City,St,Zip ______________________

Phone (H): __________ Phone (C): __________

Guarantor Employer: __________ Address/Phone# __________

Insurance Information:

Primary Insurance: __________ Policy # __________ Subscriber: __________

SS# __________ Group # __________ Group Name: __________

Address,City,St,Zip __________ Phone # __________

Secondary Insurance: __________ Policy # __________ Subscriber: __________

SS# __________ Group # __________ Group Name: __________

Address,City,St,Zip __________ Phone # __________

Additional Information:

Do you have a Living Will? Y N Healthcare Proxy? Y N Name: __________

Medical Power of Attorney? Y N Name: __________

POLST ? Y N Would you like more information on any of the above? Y N

Medicare Questions:

Kidney Dialysis or Transplant: Y N Date: __________ United Mine Worker? Y N

Employed? Y N Retirement Date: __________ Spouse Retirement Date: __________

Accident? Y N How? __________ Date/Time __________

Hospitalized in last 60 Days? Y N Outpatient visit last 72 Hrs? Y N Where? __________