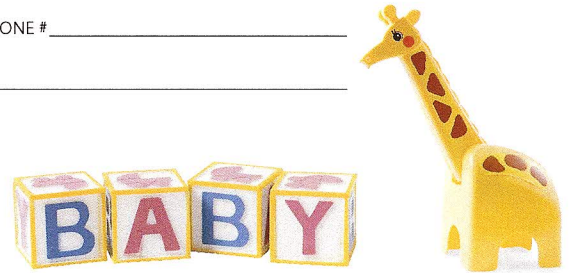


PRE-ADMISSION INFORMATION

PATIENT INFORMATION *(Please print)*

PATIENT _____
 LEGAL NAME _____
 ADDRESS _____
 CITY/STATE _____
 ZIP CODE _____
 DATE OF BIRTH _____
 AGE _____ SEX _____ RACE _____
 MARITAL STATUS _____
 HOME PHONE # _____
 SOCIAL SECURITY# _____
 EMPLOYER _____
 EMPLOYER ADDRESS _____
 EMPLOYER PHONE # _____

SPOUSE _____
 LEGAL NAME _____
 ADDRESS _____
 CITY/STATE _____
 ZIP CODE _____
 SOCIAL SECURITY # _____
 EMPLOYER _____
 EMPLOYER ADDRESS _____
 EMPLOYER PHONE # _____
 OCCUPATION _____



INSURANCE INFORMATION

(PRIMARY)
 INSURANCE COMPANY _____
 PHONE # _____
 POLICY # _____
 ID # _____ GROUP # _____
 POLICY HOLDER NAME _____

(SECONDARY)
 INSURANCE COMPANY _____
 PHONE # _____
 POLICY # _____
 ID # _____ GROUP # _____
 POLICY HOLDER NAME _____

MEDICAL INFORMATION

ESTIMATED DUE DATE _____
DOCTOR'S NAME _____
 HAVE YOU EVER BEEN A PATIENT AT NRMCMC? YES NO
 IF YES, UNDER WHAT NAME? _____
WHO DO YOU WANT TO CALL IN CASE OF EMERGENCY?
1ST CHOICE: NAME _____
 RELATIONSHIP _____
 PHONE # _____
2ND CHOICE: NAME _____
 RELATIONSHIP _____
 PHONE # _____

REGARDLESS OF YOUR AGE, DO YOU HAVE
 MEDICARE COVERAGE? YES NO
 ARE YOU A FULL-TIME STUDENT? YES NO
 ARE YOU A SMOKER? YES NO
 HAVE YOU EVER APPLIED FOR AHCCCS? YES NO
 DO YOU WANT TO APPLY FOR AHCCCS? YES NO

FOR OFFICE USE ONLY

