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 NRMC? 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

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