STANDARD PRE-ADMISSION RECORD

Scheduled Admission/Due Date

PLEASE COMPLETE BOTH SIDES OF FORM AND BRING ON DATE OF INITIAL VISIT (*DO NOT MAIL).* PLEASE NOTE:
1. Report to Patient Registration. Bring health card to hospital. **PLEASE SIGN FORM** **2.** Obstetrical patients register with 4BC or Patient Registration depending on time of day.

PATIENT'S PERSONAL INFORMATION

Last name	First name	Prior surname(s)/ maiden name	❒ Male ❒ Female
Address	Apt. #	Church	
City, town, village	Family doctor	Surgeon	
Postal code	County/township	**Allergies**	
Lot, concession	Home phone #	Business phone #	
Age	Date of birth year / month / day	Overnight stay at any hospital in the past 6 months? ❒ No ❒ Yes Date Hospital	

Name of person to notify in case of need (spouse, parent, guardian, guarantor, etc.)	Relationship to patient	
Address ❒ Same as above, or	Home phone	Business phone # and ext.
Is this admission due to pregnancy? ❒ No ❒Yes	Midwife	
Please state which pregnancy this is:	Obstetrician	

HEALTH INSURANCE INFORMATION

Is patient covered under Ontario Health Insurance Plan? ❒ No ❒ Yes Last name on Health Card:	Health Insurance Number	Version code

Do you have supplementary insurance for semi or private coverage? ❒ No ❒ Yes
PLEASE COMPLETE if you have supplementary insurance for all day surgery, inpatient and outpatient procedures.

If yes, name of insurance company	Policy, Group, or Contract #
Certificate in name of ❒ Patient ❒ Other—please complete name below	Certificate or I.D. #
Name	Employer's name/ Employer's address
Relationship to patient	
Insurance coverage provided by employer ❒ No ❒Yes	Employer's telephone number

ACCOMMODATION

❒ PRIVATE ROOM

❒ SEMI-PRIVATE ROOM

❒ WARD ROOM (OHIP)

(Semi $165.00/day; Private $195.00/day)
Rates are subject to change without notice.

PLEASE CHECK YOUR INSURANCE POLICY COVERAGE CAREFULLY BEFORE REQUESTING PREFERRED ACCOMMODATION. PAYMENT WILL BE EXPECTED ON OR AFTER DISCHARGE FROM THE HOSPITAL OF ANY ADDITIONAL COSTS OVER AND ABOVE YOUR INSURANCE COVERAGE

I UNDERSTAND THAT I AM RESPONSIBLE AND LIABLE FOR ALL COSTS INCURRED DURING MY OR THE ABOVE NOTED PATIENT'S STAY WHICH ARE NOT COVERED BY THE ONTARIO HEALTH INSURANCE PLAN (OHIP). I FURTHER AGREE TO PAY ALL ADDITIONAL CHARGES ON DISCHARGE. I HERE BY AUTHORIZE GRAND RIVER HOSPITAL TO RELEASE ANY INFORMATION THAT MAY BE REQUIRED FOR INSURANCE PURPOSES.

Date ______________ **Signature of Responsible Party / Patient or Policy Holder X_____**

At this time the hospital is unable to verify the coverage for inpatients or any applicable deductible relating to semi-private and private accommodation, and therein lies the responsibility of the patient / parent / guardian.

GRH1795 (06-02) **PLEASE SEE REVERSE SIDE FOR CREDIT CARD/ WSIB / OUT OF PROVINCE INFO IF APPLICABLE**

GRAND RIVER HOSPITAL

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WSIA INFORMATION (FORMERLY WCB)

Is this admission because of a work-related injury? No

Yes—Employer's name ____________________

Employer's address ____________________

____

Date of injury year / month / day

Employer's telephone number

(_______) _______

If yes, claim number

Social Insurance Number

OUT OF PROVINCE INFORMATION

Address of province of origin

____

____

Home phone number (_______)

Business phone number (_______)

Is this: Temporary move? Permanent move?

Provincial Health Care Number

Reason here

Vacation
Medical Referral
Temporary employment
Other _

Is this admission the result of a motor vehicle accident? No Yes

IT IS IMPORTANT THAT THIS FORM BE COMPLETED IN ITS ENTIRETY AND SIGNED PRIOR TO COMING TO THE HOSPITAL, AS IT WILL MAKE THE REGISTRATION PROCESS QUICKER. IF A PRE-ANAESTHETIC PATIENT QUESTIONNAIRE IS INCLUDED, PLEASE ENSURE THAT IT IS COMPLETED AS WELL.

Should there be any questions that arise while completing either of the forms or if you require directions, a 24-hour help line can be utilized that will provide assistance from a registration clerk. Please dial 749-4300 ext. 2633.

Please bring both the Pre-Admission form and Anaesthetic Questionnaire (if applicable) when you come to the hospital. **Do not mail these forms**. Obstetrical patients, please include this form with your other obstetrical physician papers.

Other suggested information to bring:

- Complete list of medications you are currently taking
- Your Health Card
- Your pacemaker card from the manufacturer if you have a pacemaker
- If you have any questions about your surgery/delivery please write them down and they will be answered at the time of your admission

CREDIT CARD INFORMATION—if OHIP or private insurance does not cover all charges, your credit card will be billed.

❒ VISA
❒ MASTERCARD
❒ AMERICAN EXPRESS

Name of card holder (please print) ____________________

Account number ____________________

Expiry date ____________________

Signature ____________________