

TEMPLE COMMUNITY HOSPITAL

Pre-Admission Form

Department of Admissions

PLEASE RETURN TO:
 Temple Community Hospital
 235 N. Hoover Street
 Los Angeles, California 90004
 Attention: Pre-Admissions
 or fax to: (213) 388-1959

INSTRUCTIONS:

1. Please print clearly and complete all information
2. If you require assistance in completing this form, please call (213) 382-7252 ext. 250
3. If possible, please furnish a copy of your insurance card (front and back)
4. Please remember to bring your insurance identification card when you come in to be admitted.
5. Please mail or fax this form.

PATIENT TO COMPLETE:								
Name of Attending Physician		Telephone No. of Attending Physician ()		Name of Other Physician		Telephone No. of Other Physician ()		
Name of Patient (<i>Last, First, Middle Initial</i>)			Birthdate		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Race/Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
Name Used If Previously Registered		Driver's License Number		State		Marital Status		
Address (<i>Number, Street, City, State, Zip Code</i>)								
Maiden Name		Mother's Maiden Name		Social Security Number		Birthplace (<i>City, State, Country</i>)		
Occupation		Employer		Address of Employer (<i>Number, Street, City, State, Zip Code</i>)				
SPOUSE OR RESPONSIBLE PARTY:								
Name of Spouse or Responsible Party (<i>Last Name, First Name, Middle Initial</i>)						Relationship to Patient		
Address (<i>Number, Street, City, State, Zip Code</i>)								
Occupation		Employer		Address of Employer (<i>Number, Street, City, State, Zip Code</i>)				
NEAREST LOCAL RELATIVE OR FRIEND:								
Name of Nearest Local Relative or Friend (<i>Last Name, First Name, Middle Initial</i>)						Relationship to Patient		
Address (<i>Number, Street, City, State, Zip Code</i>)								
INSURANCE INFORMATION:								
Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Hospital Insurance		Medicare Number		Hospital Effective Date		Medical Effective Date		If Co-Insurance/No.
<input type="checkbox"/> Blue Cross: State CA <input type="checkbox"/> Blue Shield		Group Number		Certificate/Subscriber Number		Coverage Code		
Name of Subscriber			Relationship of Subscriber to Patient			Name of Policy Holder		
<input type="checkbox"/> Other Insurance		Name of Other Insurance Company		Group/Policy/Union Local Number		Other I.D. Number		
Name of Policy Holder			Relationship of Subscriber to Patient			Telephone Number/Address for Insurance		
Does your insurance require a second option? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, did you obtain a second option? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please forward or bring a copy with this form.				
Does your insurance require pre-review? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, has the pre-review been approved? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Pre-review Reference Number				
Name and Address of Pre-Review Organization				Telephone Number ()				
OTHER INFORMATION								
Do you anticipate that you will need assistance upon discharge from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Are you being admitted from a: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Skilled Care Facility <input type="checkbox"/> Convalescent Home <input type="checkbox"/> Other (please specify): _____								
AUTHORIZATION TO VERIFY INSURANCE COVERAGE								
<i>I HEREBY AUTHORIZE TEMPLE COMMUNITY HOSPITAL TO CONTACT MY INSURANCE COMPANY TO VERIFY MY INSURANCE.</i>								
Signature of Patient:			Date Signed:			Signature of Insured Party:		