BETHESDA HEALTH

Procedure Pre-Registration

Date of procedure: ______________________ Physician: ________________________________

Location of Procedure: Bethesda Hospital East________ Bethesda Hospital West________
Boca YMCA ____________ Boynton YMCA _____________ Bethesda Health City __________

Patient Information:

*Legal first Name: ____________________ Middle: __________ *Last:____________________

*Date of Birth ___________________________ Social Security Number: ___________________

Marital Status: Single ______ Married ______ Divorced ______ Widowed______

*Address: ____

*City: ___________________________ *Zip code: _________ *Home phone:_______________

Cell phone number: ________________________ Work phone number: ___________________

E-mail address: ____

Primary language spoken in the home: ____

*Race: Asian _______ Black or African American _______ American Indian/Alaskan Native_______ White ______ Other______ Decline to specify ______

Ethnicity: Hispanic _______ Non-Hispanic ______ Prefer not to answer ________

Do you want us to list a religious affiliation (if yes, please state religion): _____________

*Place of employment: ____

Employer phone number: _______________________________Occupation: ________________

Employer address: ____

City ____ Zip code: _________________

***Name of Spouse/Significant other**: ____

Address (if different): ____

City: ______________________________Zip code: ________*Home phone: ________________

If you have insurance that you'd like us to bill for you, please provide the following:

Name of Insurance Company: ____

Policy number: _________________________________ Group number: ____________

Address for claims: ____

City: _________________________Zip code: _____________Phone: _______________

Name of the subscriber: ____

If other than the patient, subscriber's date of birth ______________________________

Social security number: ____________________relationship: ____________________

If this is insurance through your employer or if you are a dependant on a group plan, please provide the name of the employer:

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Are the services to be performed the result of an auto accident? Yes ______ No _____

Are the services to be performed the result of a work related injury? Yes ____ No ____

Florida law requires that we inquire about Advance Directives. Do you have a living will or surrogate? If so, please bring copies of your Advance Directives to the Hospital so that it can be placed in your records. Yes ____ No ____

If you do not have insurance and would like assistance, please indicate here and a financial representative will contact you. Yes ___________ No ___________

Do you require any special assistance that our staff should be aware of for your upcoming service?

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FAX THIS COMPLETED FORM TO:

Bethesda Central Scheduling
Attn: Pre-registration
Fax: 561-735-7031