MATERNITY PREADMISSION

Patient Information:

Patient Last Name: ____________ First Name: ____________ Maiden Name: ____________

Street: ____________ City: ____________ State: ______ Zip: ______

Birth Date: ___ | ___ | ___ Social Security Number: ____________ Race: ____________

Marital Status: ____________ Religion: ____________ Smoker: ☐ Yes ☐ No Childbirth Classes: ☐ Yes ☐ No

Primary Insured's Information *(may be the same if patient):*

Responsible Party Last Name: ____________ First Name: ____________

Social Security Number: ____________ Patient's Relationship to Responsible Party: ____________

Street: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Birth Date: ___ | ___ | ___

Spouse/Next of Kin (NOK) Information:

Spouse/NOK Last Name: ____________ First Name: ____________

Social Security Number: ____________ Patient's Relationship to Responsible Party: ____________

Street: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Birth Date: ____________

Employment Information:

Patient's Employer Name: ____________ Status: ☐ Full-time ☐ Part-time

Street: ____________ City: ____________ State: ______ Zip: ______

Work Phone: ____________

Spouse/NOK Employer Name: ____________ Status: ☐ Full-time ☐ Part-time

Street: ____________ City: ____________ State: ______ Zip: ______

Work Phone: ____________

Reason for Admission: ____________

____

If admission is pregnancy related, date of last menstrual period: ___ | ___ | ___

Admitting Physician Name: ____________

Have you been and Ellis patient before? ☐ Yes ☐ No Expected date of admission: ___ | ___ | ___

Thank You for providing this important information.

(Please complete front and back)

BELLEVUE WOMAN'S CENTER
2210 Troy-Schenectady Road, Niskayuna, NY 12309

518.346.9400
ellismedicine.org

Insurance Information:

Primary Insurance Company Name: ______________________ Plan Code: ______________

Street: ______________________ City: ______________________ State: ________ Zip: ________

Group Number: ______________________ ID Number *(include prefix & suffix):* ______________________

Policyholder Last Name: ______________________ First Name: ______________________

Patient's Relationship to Policyholder: ______________________

Secondary Insurance Company Name: ______________________ Plan Code: ______________

Street: ______________________ City: ______________________ State: ________ Zip: ________

Group Number: ______________________ ID Number *(include prefix & suffix):* ______________________

Policyholder Last Name: ______________________ First Name: ______________________

Patient's Relationship to Policyholder: ______________________

Third Insurance Company Name: ______________________ Plan Code: ______________

Street: ______________________ City: ______________________ State: ________ Zip: ________

Group Number: ______________________ ID Number *(include prefix & suffix):* ______________________

Policyholder Last Name: ______________________ First Name: ______________________

Patient's Relationship to Policyholder: ______________________

Authorization for Release of Information: I hereby authorize and direct Ellis Hospital or any physician(s) involved in my care, having treated me, to release (by facsimile when necessary) to governmental agencies, insurance carriers, insurance policy holder, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Uniform Assignment: I hereby assign, transfer, and set over to Ellis Hospital or any physician(s) involved in my care, sufficient monies an/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependents at Ellis Hospital.

Payment Agreement: I/we hereby guarantee payment of the expenses incurred by the patient named on the reverse side during this admission for services rendered by the Ellis Hospital. I/we understand that the hospital bill is due and payable in full by cash or by appropriate insurance coverage upon discharge of said patient. Ellis will cooperate by submitting a claim for the hospital charges to the Insurance carrier but the final responsibility rests with the patient and/or the guarantor(s).

Date: ___ | ___ | ___ *Signature of hospital witness:* ______________________

Signature of responsible party: ______________________

Relationship to patient: ______________________

Street: ______________________

City: ______________ *State:* ______ *Zip:* ______

For Patients Entitled to Medicare Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date: ___ | ___ | ___ *Signature of patient or authorized representative* ______________________

PLEASE NOTE:

Payment of deductible co-insurance is expected at time of discharge.

Special financial arrangements must be submitted to the business office for approval before or at the time of admission.

Please check with your insurance for possible pre-certification or managed care requirements.