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.