Pre-admission Form

(PLEASE PRINT CLEARLY)

RICE MEMORIAL HOSPITAL
301 Becker Avenue S.W. Willmar, Minnesota 56201

To pre-register by phone , please call (320) 231-4234 or (320) 231- 4545 or 1-800-854-5093

Have you ever been a patient at Rice Hospital before?
[ ] Yes [ ] No [ ] Maybe

FOR CLINIC USE ONLY
Date of Admission: ______________________
Type of Admission:_Bed Patient_Same Day
Physician: ______________________________

Demographics

Last Name ________ First Name ________ Middle Name ________ Preferred Name ________ ____/____/____ Social Security #

Permanent Street Address ________ Apt. or P.O. Box # City State Zip Code ________ [ ] M [ ] F Gender

(______) - ______ Cell Phone ( ) - ______ Work Phone (______) - ______ [ ] Home [ ] Cell [ ] Work Home Phone
Preferred Contact (check one)

____/____/____ Date of Birth ____/____/____ Date of Admission/Due Date Reason: [ ] Surgery [ ] OB
[ ] Asian [ ] Black [ ] Caucasian [ ] Indian (American)
[ ] Decline to answer [ ] Unknown [ ] Other____________________

[ ] Married [ ] Single [ ] Widowed [ ] Divorced ________ Maiden / Other Name ________ Name Change in Future ____/____/____ Date of Change

Origin of Birth: Birth Country____________________Birth State:__________________Preferred Language:________________________

Ethnic Group: [ ] Hispanic [ ] Non-Hispanic Primary Clinic:___________________________

Communication Needs? [ ] No [ ] Yes If yes, please explain. (ie. hearing aids, interpreter. etc.)

Physician

Admitting Physician or Surgeon ________ Primary Physician & City ________ Referring Physician ________

Employment

[ ] Full-Time [Part-Time [ ] Not Employed [ ] Student [ ] Retired______/____/______Date of Retirement

Patient Employer ________ Address City State Zip Code

(______)______ - ______ Phone ________ Occupation

Religion

Religion ________ Place of Worship & City ________ [ ] English [ ] Somali [ ] Spanish [ ] Other ________________ Language

Guarantor *Complete only if different than patient * (person responsible for paying bill after insurance pays their portion)

Last Name ________ First Name ________ Middle Name ________ SSN# ________ ____/____/____ DOB

Permanent Address ________ Apt. or P.O. Box # City State Zip Code

(______) - ______ Phone (______) - ______ Cell Phone (______) - ______ Work Phone [ ] Home [ ] Cell [ ] Work Home
Preferred Contact (check one)

Occupation ____________________ [ ] Full-Time [ ] Part-Time [ ] Not Employed [ ] Retired______/_____/______Date of Retirement

Emergency Contact

Primary Emergency Contact ____________ Relationship to patient ____________

(   )   -   Home Phone (   )   -   Cell Phone (   )   -   Work Phone [ ] Home [ ] Cell [ ] Work Preferred Contact (check one)

Permanent Street Address ____________ Apt. or P.O. Box # ____ City ____ State ____ Zip Code ____

Secondary Emergency Contact ____________ Relationship to Patient ____________

(   )   -   Phone ( )   -   Cell Phone (   )   -   Work Phone [ ] Home [ ] Cell [ ] Work Home Preferred Contact (check one)

Insurance: ***(If your insurance requires prior authorization or for questions regarding out of pocket expenses, please contact your insurance co.)***

Primary Insurance:

Name of Insurance ____________ Member # ____ ID/Policy # ____ Group # ____

Name of Policy Holder ____________ / / Date of Birth ____ - - Social Security # ____ Phone # ____

Employer of policy holder (if different than patient) ____________ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

Secondary Insurance:

Name of Insurance ____________ Member # ____ ID/Policy # ____ Group # ____

Policy Holder ____________ / / Date of Birth ____ - - Social Security # ____ Name of Phone # ____

Employer of policy holder (if different than patient) ____________ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

Other Insurance:

Name of Insurance ____________ Member # ____ ID/Policy # ____ Group # ____

Policy Holder ____________ / / Date of Birth ____ - - Social Security # ____ Name of Phone # ____

Employer of policy holder (if different than patient) ____________ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

For surgical patients only:

Have you had or scheduled a physical within 30 days prior to your admission? [ ] Yes [ ] No ____/____/____ Date ____________ With whom?

What time will you be arriving at the hospital on the day of your procedure? ____________

What phone number may we contact you on the day of your procedure for unexpected schedule changes (   )   -

For expecting mothers only:

Do you currently have a breast pump you are planning to use? [ ] Yes [ ] No

If 'No' to the question above, would you like Rice Home Medical to verify your insurance coverage for a breast pump? [ ] Yes [ ] No

Please call, mail or return this form prior to your scheduled visit.
If you are uninsured, have concerns about financial responsibility, or have questions regarding financial assistance, call (320) 231-4371.
If you would like to receive an estimate for your out-of-pocket expenses, please call (320) 231-4234 or (320) 231-4545 or 1-800-854-5093.