Maternity Pre-Admission

Return Form to Admitting Office (FAX: 914-366-1559)

Description of Service: _____

P H E L P S
Phelps Memorial Hospital Center
701 N. Broadway . Sleepy Hollow, NY 10591 . 914-366-3000

Patient Information:

Name: _____
Street: _____ Apt# _____
City: _____
State: _____ Zip Code: _____
Home Phone#: _____ Other #: _____
Email Address: _____
Marital Status: ❒ Married ❒ Single ❒ Widowed
❒ Divorced ❒ Separated ❒ Life Partner

Next of Kin:

Name: _____
Street: _____ Apt# _____
City: _____
State: _____ Zip Code: _____
Home Phone#: _____ Other #: _____
Relationship to Patient: _____

Guarantor:

❒ Same as Patient ❒ Same as Next of Kin ❒ Other:
Name: _____
Street: _____ Apt# _____
City: _____
State: _____ Zip Code: _____
Home Phone#: _____ Other #: _____
Social Security # : _____
Guarantor's Employer: _____
Street: _____
City: _____
State: _____ Zip Code: _____

Primary Physician:

Name: _____
Telephone: _____

Referring/Attending Physician:

Name: _____
Telephone: _____

Reason for visit: _____

Diagnosis: _____

Expected Date of Admission/Appointment date:

_____

Do you have Advance Directives?

❒ Living Will ❒ Healthcare Proxy
❒ Power of Attorney ❒ None

If you would like copies on file at the hospital, please bring with you on date of service.

Date of birth: _____ Sex: ❒ Male ❒ Female
Social Security # : _____
Race: _____
Religion: _____
Primary Language: _____
Employer: _____
Street: _____
City: _____
State: _____ Zip Code: _____

Emergency Contact:

Name: _____
Street: _____ Apt# _____
City: _____
State: _____ Zip Code: _____
Home Phone#: _____ Other #: _____
Relationship to Patient: _____

Insurance Information:

Name of Insurance Co: _____
Street: _____
City: _____
State: _____ Zip Code: _____
Telephone: _____
Policy # (ID#): _____
Subscriber's name: _____
Patient's relationship to subscriber: _____
Group #: _____
Effective date: _____
Subscriber's Social Security #: _____
Subscriber's date of birth: _____
Subscriber's Employer: _____
Street: _____
City: _____
State: _____ Zip Code: _____
If Workman's Comp or No Fault, date of accident:
_____

Secondary Insurance (if any):

Name of Insurance Co: _____
Street: _____
City: _____
State: _____ Zip Code: _____
Telephone: _____
Policy # (ID#): _____
Subscriber's name: _____
Patient's relationship to subscriber: _____
Subscriber's date of birth: _____
Subscriber's Social Security #: _____
Effective date: _____
Group #: _____
Subscriber's Employer: _____
Street: _____
City: _____
State: _____ Zip Code: _____
If Workman's Comp or No Fault, date of accident:
_____