



**CONFIDENTIAL ADMISSION FORM**

(Please Print)

HAVE YOU RECEIVED ANY TREATMENT IN THIS HOSPITAL BEFORE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
HAS YOUR NAME CHANGED SINCE A PREVIOUS VISIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF "YES", PLEASE INDICATE PREVIOUS NAME
DO YOU HAVE A HOSPITAL GREEN CARD? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF "YES", PLEASE INDICATE CARD NUMBER
FAMILY PHYSICIAN	ATTENDING PHYSICIAN
ALLERGIES	

PATIENT SURNAME		<b>HOSPITAL AND MEDICAL INSURANCES</b>	
GIVEN NAME(S)		<p style="text-align: center;"><i>OUT OF PROVINCE?</i> <b>ASK FOR MINISTRY OF HEALTH FORM AT TIME OF ADMISSION</b></p>	
DATE OF BIRTH	SEX	MARITAL STATUS	DO YOU HAVE ONTARIO HEALTH INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>
Day Month Year		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW(ER) <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> COMMON LAW	HEALTH CARD NUMBER (10 DIGITS) _____ VERSION LETTERS _____
ADDRESS		Apt # or Unit # _____	
CITY	PROVINCE	POSTAL CODE	SURNAME & INITIALS AS SHOWN ON HEALTH CARD

HOME PHONE	BUSINESS PHONE	<b>ACCOMMODATION TYPE REQUESTED</b> (Please Indicate In Areas Below)	
EMPLOYER NAME & ADDRESS		<input type="checkbox"/> WARD <input type="checkbox"/> SEMI-PRIVATE <input type="checkbox"/> PRIVATE	
PREFERRED LANGUAGE	RELIGION	<p style="text-align: center;">◆ PLEASE CHECK YOUR INSURANCE COVERAGE WITH YOUR EMPLOYER, AS INSURANCE COVERAGES CHANGE FREQUENTLY. PATIENTS ARE RESPONSIBLE FOR ENSURING THAT COVERAGE IS IN EFFECT. ◆</p> <input type="checkbox"/> I do not have insurance coverage. Please bill me directly. <input type="checkbox"/> I have some coverage. Please bill my insurance company and bill me for any remaining balances. <input type="checkbox"/> I have full coverage. Please bill my insurance company directly.	

<b>NEXT-OF-KIN INFORMATION</b>		<p style="text-align: center;"><b>ALL SELF-PAY ACCOUNTS SHOULD BE PAID PRIOR TO DISCHARGE AT THE CASHIER/INFORMATION DESK.</b></p>		
NAME				
ADDRESS				
CITY	PROVINCE			POSTAL CODE
HOME PHONE	BUSINESS PHONE			
RELATION TO PATIENT		<p style="text-align: center;"><b>EXTENDED HEALTH CARE BENEFIT INSURANCE INFORMATION AND COVERAGE</b></p>		

DO YOU HAVE A SUBSTITUTE DECISION MAKER? <input type="checkbox"/> YES <input type="checkbox"/> NO		MY MAXIMUM INSURANCE COVERAGE IS: <input type="checkbox"/> SEMI-PRIVATE \$ _____ /day or _____ % <input type="checkbox"/> PRIVATE \$ _____ /day or _____ %	
NAME		NAME OF INSURANCE COMPANY	
ADDRESS		GROUP POLICY NUMBER _____ DIVISION _____	
CITY		IDENTIFICATION OR CERTIFICATE NUMBER	
PROVINCE		SURNAME AND INITIAL ON CERTIFICATE	
POSTAL CODE		SOCIAL INSURANCE NUMBER OF CERTIFICATE HOLDER	
HOME PHONE		PATIENT RELATION TO INSURANCE HOLDER <input type="checkbox"/> HOLDER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	
BUSINESS PHONE			
RELATION TO PATIENT			

Do You Have an Advance Directive? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes", Bring Copy to Hospital)		<b>EMPLOYER INFORMATION OF INSURANCE HOLDER</b>	
		EMPLOYER NAME	
		EMPLOYER'S ADDRESS	

**Standard Telephone Charge: \$12.00 each visit**