PROVIDENCE HOSPITAL

PRE-ADMISSION FORM

PROVIDENCE
Alaska
Medical Center
P.O. BOX 196604 • ANCHORAGE, ALASKA 99519-6604
PHONE (907) 562-2211

THE COMMITMENT CONTINUES

PROCEDURE INFORMATION - REQUIRED FOR REGISTRATION

WHAT TYPE OF SERVICE ARE YOU REGISTERING FOR? ☐ MATERNITY ☐ DAY SURGERY ☐ GENERAL SURGERY ☐ OTHER:		FACILITY DIRECTORY ☐ YES ☐ NO
DIAGNOSIS/SYMPTOMS:		DATE OF ONSET
EXPECTED DATE OF ADMISSION	ADMITTING PHYSICIAN:	IF MATERNITY, DATE OF LAST MENSTRUAL PERIOD

PATIENT INFORMATION

PATIENT NAME Last First MI					PREVIOUS NAME	
SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	MAR. STAT	RACE	RELIGION	CHURCH AFFILIATION
PATIENT MAILING ADDRESS City State Zip			POSSESS ADV. DIRECTIVE?	IF YES, WHERE IS COPY KEPT? ☐ PROVIDENCE OTHER:		
HOME PHONE	EMPLOYER		WORK PHONE	OCCUPATION		

RESPONSIBLE PARTY (IF OTHER THAN THE PATIENT)

FOLD HERE

LAST NAME FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
ADDRESS City State Zip	HOME PHONE		WORK PHONE

EMERGENCY CONTACT

LAST NAME FIRST MI	HOME PHONE	WORK PHONE	REL. TO PATIENT

HAVE YOU EVER BEEN IN THE MILITARY?	YES	NO	ARE YOU ELIGIBLE FOR ALASKA NATIVE BENEFITS AT ANS HOSPITAL?	YES	ARE YOU A U.S. CITIZEN?	YES
ARE YOU USING YOUR VA MEDICAL BENEFITS? If yes, then you must complete a VA 1010.	YES	NO		NO		NO

SELF PAY?	YES	WORKMAN'S COMPENSATION? (If yes, please complete next four blocks.)	YES	WORKMAN'S COMP. CARRIER	DATE OF INJURY	CLAIM NUMBER
	NO		NO			

INSURANCE 1 — REMEMBER TO PRE-AUTHORIZE WITH YOUR INSURANCE COMPANY! — INCLUDE MEDICAID INFORMATION

PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS City State Zip				
SUBSCRIBER NAME (Insured Person)	SUBSCRIBER NUMBER	GROUP NUMBER	SUB. SEX F M	EMPLOYMENT STATUS (Check One)	
				Full-Time / Part-Time / Not Employed	
				Self-Employed / Retired / Active Military	
SUBSCRIBER EMPLOYER	SUBSCRIBER WORK PHONE	SUBSCRIBER DATE OF BIRTH	HOW RELATED TO PT.?	AUTHORIZATION #?	

INSURANCE 2

FOLD HERE

PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS City State Zip				
SUBSCRIBER NAME (Insured Person)	SUBSCRIBER NUMBER	GROUP NUMBER	SUB. SEX F M	EMPLOYMENT STATUS (Check One)	
				Full-Time / Part-Time / Not Employed	
				Self-Employed / Retired / Active Military	
SUBSCRIBER EMPLOYER	SUBSCRIBER WORK PHONE	SUBSCRIBER DATE OF BIRTH	HOW RELATED TO PT.?	AUTHORIZATION #?	

INSURANCE 3

PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS City State Zip				
SUBSCRIBER NAME (Insured Person)	SUBSCRIBER NUMBER	GROUP NUMBER	SUB. SEX F M	EMPLOYMENT STATUS (Check One)	
				Full-Time / Part-Time / Not Employed	
				Self-Employed / Retired / Active Military	
SUBSCRIBER EMPLOYER	SUBSCRIBER WORK PHONE	SUBSCRIBER DATE OF BIRTH	HOW RELATED TO PT.?	AUTHORIZATION #?	

Fold and Seal

Cosmetic Surgeries

Elective inpatient and outpatient cosmetic surgeries require payment in full at time of registration. If your insurance has determined that this is a covered service and a payment authorization is obtained prior to registration, the balance due at point of registration will be the expected balance remaining after insurance.

The Mission of the Sisters of Providence

Providence Alaska Medical Center is owned and operated by the Sisters of Providence. It is a part of a network of not for profit care giving agencies, through which, the Sisters work to fulfill their mission — to make necessary health care services available to all individuals regardless of their ability to pay. The Sisters of Providence have been servicing people throughout Alaska since 1902.

If your hospital bill is a financial hardship, please let us know. We will be happy to work with you to establish an equitable payment arrangement or to assist you in applying for other assistance programs.

Providence Alaska Medical Center is a member of the Catholic Hospital Association.

PLACE
POSTAGE
STAMP
HERE

ADMITTING DEPARTMENT
PROVIDENCE ALASKA MEDICAL CENTER
PO BOX 196604
ANCHORAGE AK 99519-6604