Mission Hospital
ST. JOSEPH HEALTH SYSTEM

Everything for life℠

PRE-ADMISSION INFORMATION FORM

PHONE: 949-364-1400 x7222 FAX: 949-365-2306

SURGERY ☐ Yes ☐ No PREGNANCY ☐ Yes ☐ No OTHER _____

DATE OF ADMISSION OR DUE DATE _____ PHYSICIAN NAME _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ PRIMARY LANGUAGE _____ SEX M / F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ RELIGION _____ HOUSE OF WORSHIP _____

MARITAL STATUS _____ SOCIAL SECURITY # _____

DO YOU HAVE AN ADVANCED DIRECTIVE ☐ Yes ☐ No

OCCUPATION _____ ☐ I am currently unemployed

EMPLOYER'S NAME _____ EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

PATIENT'S ETHNICITY ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asia/India/Pacific/Isles ☐ Other

EMERGENCY CONTACT

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ RELATIONSHIP _____

PATIENT'S INSURANCE INFORMATION

☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Medicare ☐ MediCal ☐ Other ☐ I am currently uninsured

INSURANCE COMPANY NAME _____

PHONE _____ GROUP # _____ POLICY # _____

MEDICAL GROUP NAME (if applicable) _____

PRIMARY CARE PHYSICIAN _____

SUBSCRIBER INFO IF DIFFERENT _____ NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

SECOND INSURANCE INFORMATION (if applicable)

☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Medicare ☐ MediCal ☐ Other ☐ I am currently uninsured

INSURANCE COMPANY NAME _____

PHONE _____ GROUP # _____ POLICY # _____

MEDICAL GROUP NAME (if applicable) _____

PRIMARY CARE PHYSICIAN _____

SUBSCRIBER INFO IF DIFFERENT _____ NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

UPON ARRIVAL IN ADMITTING, PLEASE HAVE YOUR VALID PHOTO ID AND INSURANCE CARD READY. PATIENT'S DEDUCTIBLE AND EST. CO-PAY ARE REQUESTED AT TIME OF ADMISSION. ALL MAJOR CREDIT CARDS ACCEPTED.

213453 (8/07)

BUSINESS REPLY MAIL

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POSTAGE WILL BE PAID BY ADDRESSEE

Mission Hospital
ST. JOSEPH HEALTH SYSTEM

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ST. JOSEPH
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