



PRE-ADMISSION FORM

PATIENT INFORMATION			DATE OF PROCEDURE / TREATMENT / EXAM
NAME: (Last, First, MI)			
ADDRESS:			PHONE:
CITY:		STATE:	ZIP CODE:
MARITAL STATUS:	MAIDEN / FORMER NAME:		DATE OF BIRTH:
RACE / ETHNICITY: (REQUIRED BY STATE OF WIS.)		NAME OF PROCEDURE / TREATMENT / EXAM	
ADMITTING PHYSICIAN:		SOCIAL SECURITY NUMBER:	
EMPLOYER:		OCCUPATION:	
EMPLOYER ADDRESS:		LENGTH OF EMPLOYMENT:	EMPLOYMENT STATUS FT PT UNEMPLOYED
CITY:		STATE:	ZIP CODE:
ALLERGIES: (SPECIFY) YES NO	RELIGION:	PLACE OF WORSHIP:	
PRIMARY CARE PHYSICIAN: (IF DIFFERENT FROM ADMITTING PHYSICIAN)			

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL ARRANGEMENTS

NAME:		DATE OF BIRTH:
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:		RELATIONSHIP:
EMPLOYER:		OCCUPATION:
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:
LENGTH OF EMPLOYMENT:		EMPLOYMENT STATUS: FT PT UNEMPLOYED

INSURANCE INFORMATION

PRIMARY	SECONDARY
NAME AND ADDRESS OF INSURANCE: <i>(If on card)</i>	NAME AND ADDRESS OF INSURANCE: <i>(If on card)</i>
SUBSCRIBER / POLICY HOLDER:	SUBSCRIBER / POLICY HOLDER
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
SUBSCRIBER NUMBER:	SUBSCRIBER NUMBER:
GROUP NUMBER:	GROUP NUMBER:
GROUP NAME:	GROUP NAME:

PERSON TO CONTACT

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE #	ALTERNATE PHONE #	
RELATIONSHIP TO PATIENT:		

NOTE:

1. Please call **(414) 219-6054** if you have any questions about completing this form.
2. Some insurance companies require pre-certification authorization for hospital admittance. Please be sure to contact your insurance company to inform them that you may be admitted to Aurora Sinai Medical Center. This is the best way to confirm your coverage.
3. This form is designed to make your admission faster and easier. Though we have this information, we do need you to bring your insurance card(s) when being admitted.
4. Please return this form to:

Aurora Sinai Medical Center
 Attention: Admitting Department
 945 N. 12th Street.
 P.O. Box 342
 Milwaukee, WI 53201-0342