PRE-ADMISSION FORM

Fax to (913) 345-3737 or mail to Menorah Medical Center, 5721 W. 119th St., Overland Park, KS 66209
To confirm pre-admission form received call (913) 498-7119.

PATIENT INFORMATION:

(Please type or print in black ink) Due Date: Month: _____ Day: _____ Year: _____

Email: _____ OB Doctor: _____

Name: Last: _____ First: _____ Middle: _____

Address: Street: _____

City: _____ County: _____ State: _____ Zip: _____

Phone (Home/Cell): _____ Birthdate: _____ Age: _____

Marital Status: _____ Religion: _____

Maiden Name: _____ Race: _____

Social Security #: _____ Occupation: _____

Patient's Employer: _____ Employer's Phone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____ Birthdate: _____ Social Security #: _____

Spouse's Cell Phone: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____

_____

Name of Relative or Friend for Emergency Notification ***(other than spouse)***

_____

Address Phone Relationship

BILLING INFORMATION: GUARANTOR (PERSON WHO IS FINANCIALLY RESPONSIBLE)

Name: _____ Relationship: _____

Address: _____ Phone: _____ Social Security #: _____

Employer Name & Address: _____

INSURANCE INFORMATION: PLEASE SEND COPIES OF DRIVER'S LICENSE and BOTH SIDES OF INSURANCE CARDS (the card of the person who carries the policy [self, spouse or parent]) AND ANY CLAIM FORMS. If you are covered under your parents insurance, please provide their information. PLEASE FILL OUT THIS SECTION COMPLETELY

Primary Insurance: _____ Address: _____

Company's Phone: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Birthdate: _____

Group #: _____ Policy #: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize the insurance company(ies) to pay to the hospital the benefits which would otherwise be payable to me provided that these payments do not exceed the hospital's regular charges for those services. I understand that I am financially responsible to the hospital for any charges not covered by the insurance.

Patient's Signature: _____ Guarantor's Signature: _____

OFFICE USE ONLY

Suite: _____ Arrived: _____ Gestation: _____ Diagnosis: _____