St.Francis Women's Hospital

PRE-ADMISSION FORM
MATERNITY PATIENTS ONLY
(PLEASE PRINT)

Please Fax Completed Form To: SFH Admissions (706) 596-4049
OR Mail To: St. Francis Hospital, PO Box 84022 Columbus, GA 31904 Attn: Patient Access

DATE (Month/Day/Year) _____ EXPECTED DELIVERY DATE _____ PHYSICIAN _____ PEDIATRICIAN _____ MATERNITY ADMISSION TYPE

SECTION I – PATIENT INFORMATION

PATIENT NAME _____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL MAIDEN NAME

_____ _____ _____ _____ ☐S ☐M ☐D ☐W _____
AGE DATE OF BIRTH (Month/Day/Year) RACE SOCIAL SECURITY NUMBER MARITAL STATUS (Mark One) RELIGIOUS PREFERENCE

_____ _____
PATIENT PHYSICAL ADDRESS (STREET/CITY/STATE/ZIP CODE) PATIENT MAILING ADDRESS (STREET/CITY/STATE/ZIP CODE)

SURGICAL PROCEDURE WILL BE REQUIRED:
☐YES ☐NO (IF YES, GIVE DATE OF SURGERY_____)
DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE ☐YES ☐NO
ALLERGIES: _____
SUPPORT PERSON'S NAME _____
THINGS YOU WANT THE OB STAFF TO KNOW ABOUT YOU _____

HOME PHONE NUMBER _____
CELL PHONE NUMBER _____
MAY WE LEAVE A MESSAGE ON YOUR HOME OR CELL PHONE ☐YES ☐NO
EMAIL ADDRESS: _____
OTHER CHILDREN NAMES AND AGES _____

SECTION II – PATIENT EMPLOYER

PLEASE MARK ONE: ☐Full-time ☐ Part-time ☐Retired ☐Disabled ☐Student ☐Not Employed

EMPLOYER NAME _____ Phone Number ( ) _____ Ext _____
EMPLOYER ADDRESS _____ OCCUPATION _____
(STREET/CITY/STATE/ZIP CODE)

SECTION III –SPOUSE INFORMATION

_____ _____
DATE OF BIRTH (Month/Day/Year) SOCIAL SECURITY NUMBER

SPOUSE NAME _____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL JR/SR/III

PLEASE MARK ONE: ☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Student ☐Not Employed
EMPLOYER NAME _____ Phone Number ( ) _____ Ext _____
EMPLOYER ADDRESS _____ OCCUPATION _____
(STREET/CITY/STATE/ZIP CODE)

NAME OF PERSON RESPONSIBLE FOR BILL IF DIFFERENT FROM PATIENT OR SPOUSE: _____ RELATIONSHIP _____
_____ HOME PHONE NUMBER _____ CELL PHONE NUMBER _____
GUARANTOR ADDRESS (STREET/CITY/STATE/ZIP CODE)

EMPLOYER NAME _____ Phone Number ( ) _____ Ext _____
EMPLOYER ADDRESS _____ OCCUPATION _____
(STREET/CITY/STATE/ZIP CODE)

SECTION IV –INSURANCE INFORMATION

☐Medicaid Policy Number _____ NO INSURANCE (SELF PAY) ☐YES
☐Medicare Policy Number _____

PRIMARY INSURANCE CO NAME _____ Phone Number ( ) _____ Ext _____
INSURANCE ADDRESS _____
(STREET/CITY/STATE/ZIP CODE)
Employer _____ POLICY NUMBER _____ GROUP NUMBER _____
INSURED NAME AS IT APPEAR ON INS CARD _____ SUBSCRIBER NAME _____

SECONDARY INSURANCE CO NAME _____ Phone Number ( ) _____ Ext _____
INSURANCE ADDRESS _____
(STREET/CITY/STATE/ZIP CODE)
Employer _____ POLICY NUMBER _____ GROUP NUMBER _____
INSURED NAME AS IT APPEAR ON INS CARD _____ SUBSCRIBER NAME _____

TRICARE/CHAMP VA POLICY NUMBER _____ SPONSOR STATUS: ☐ACTIVE ☐DECEASED ☐RETIRED ☐RETIRMENT DATE _____
SPONSOR NAME _____ _____ SPONSOR ID NUMBER _____

PLEASE PROVIDE A COPY OF YOUR GOVERNMENT ISSUED PHOTO ID CARD AND THE FRONT AND BACK OF ALL INSURANCE CARDS. FOR ANY QUESTIONS CALL 706-320-8007.