Lakeland HealthCare
Medical Excellence. Compassionate Care.

PRE-ADMISSION

TYPE OF SERVICE: ☐ O B

☐ Niles ☐ St. Joseph

PLEASE COMPLETE AS SOON AS POSSIBLE.

PRE-ADMISSION REGISTRATION

EXPECTED DUE DATE	DOCTOR'S NAME

PATIENT

NAME (FIRST NAME, MIDDLE NAME AT BIRTH, LAST NAME)	FORMER NAMES	EMPLOYER	OCCUPATION
ADDRESS STREET APT./LOT NO. COUNTY		ADDRESS STREET SUITE	PHONE
CITY STATE ZIP CODE PHONE		CITY STATE ZIP CODE	EXTENSION
AGE DATE OF BIRTH PLACE OF BIRTH SOCIAL SECURITY NO.			STATUS OF EMP. (✔ ONE) ☐ FULL TIME ☐ RETIRED ☐ PART TIME ☐ SELF
STATUS (✔ ONE) ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE ☐ WIDOWED	SPOUSE'S NAME	RACE ☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER	RELIGION/CHURCH
IF PATIENT IS A MINOR: MOTHER'S NAME DATE OF BIRTH		FATHER'S NAME	DATE OF BIRTH

INSURANCE INFORMATION

INS 1

INSURANCE COMPANY 1 (IF BLUE CROSS, WHAT STATE?	INSURED NAME		
ID/POLICY/CONTRACT NO.	EMPLOYER	GROUP NO.	EFFECTIVE EXPIRATION DATE
ADDRESS FOR CLAIMS BOX/STREET	CITY	STATE	ZIP CODE

INS 2

INSURANCE COMPANY 2 (IF BLUE CROSS, WHAT STATE?	INSURED NAME		
ID/POLICY/CONTRACT NO.	EMPLOYER	GROUP NO.	EFFECTIVE EXPIRATION DATE
ADDRESS FOR CLAIMS BOX/STREET	CITY	STATE	ZIP CODE

EMERG. INFO.

PERSON TO NOTIFY IN EMERGENCY	RELATION TO PATIENT	HOME PHONE
ADDRESS CITY COUNTY STATE ZIP CODE		WORK PHONE

FINANCIAL REQUIREMENTS

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Lakeland Hospital will accept your hospitalization insurance, as a courtesy to you, only if you follow these instructions:

1) Complete all information on this form.
2) Bring insurance I.D. cards/policies to Admissions.

You should also verify with your insurance company the pre-admission requirements on your insurance policy. Failure to do so may drastically reduce your benefits.

If you do not have insurance to cover this hospitalization:

1) A pre-admission deposit will be required.
2) You must also contact a financial counselor prior to admission. Call Niles at 687-1404 or 687-1408, St. Joseph at 983-8320 or 983-8241 or visit the Admitting Office between 9:00 a.m. – 4:00 p.m. Monday – Friday.

PRE-ADMISSION RELEASE FORM

I hereby authorize Lakeland Hospital, Inc., and my attending physician(s) to release all information necessary, including diagnosis, procedures to be performed, tests to be administered, etc., if required, to my employer, my insurance carrier(s) and any other third party coverage that I may provide to Lakeland Hospital and to any appropriate (or associated) pre-admission review and benefit verification when necessary.

SIGNATURE: _____ DATE: _____

NOTE: IN ORDER FOR US TO BETTER PREPARE FOR YOUR ADMISSION, **ALL PRE-ADMISSION INFORMATION MUST BE COMPLETED AND THE FORM RETURNED AS SOON AS POSSIBLE.**

IF YOU HAVE ANY QUESTIONS, PLEASE CALL NILES (269) 687-1404
ST. JOSEPH (269) 983-8808