

CONFIDENTIAL PATIENT PRE-REGISTRATION INFORMATION

Please print this form and mail to:

Admitting Office: PO BOX 5777, London, Ont. N6A 4V2 (or fax: (519) - 646-6163)

DATE OF SURGERY / PROCEDURE	ATTENDING DOCTOR	SELF PAY <input type="checkbox"/> Yes <input type="checkbox"/> No
FAMILY DOCTOR (SURNAME, FIRST NAME)	CITY / TOWN	

PATIENT INFORMATION

TITLE <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mst. <input type="checkbox"/> Miss. <input type="checkbox"/> Other :				
PATIENT'S LAST NAME		LEGAL GIVEN NAME AND INITIAL		MAIDEN NAME / OTHER NAMES
STREET ADDRESS / R. R.		CITY / TOWN	TOWNSHIP	AREA CODE / HOME TELEPHONE
COUNTY		PROVINCE	POSTAL CODE	AREA CODE / OTHER TELEPHONE
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Common-Law		SEX	AGE	DATE OF BIRTH __/__/__ YY MM DD
LANGUAGES SPOKEN (IF NOT ENGLISH)		HAVE YOU BEEN HERE BEFORE ? <input type="checkbox"/> Birth <input type="checkbox"/> Inpatient Year _____ <input type="checkbox"/> Emerg. <input type="checkbox"/> Outpatient		
RELIGION (DENOMINATION)		CHURCH OR PARISH		CITY / TOWN
IS PATIENT CURRENTLY EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self-Employed		IF YES, WHERE? (EMPLOYER AND LOCATION)		

PROVINCIAL HEALTH INSURANCE

PATIENT'S HEALTH CARD NUMBER	PROV. IF NOT ONT.	VERSION CODE	NAME AS IT APPEARS ON CARD (include spaces, hyphens, apostrophes, etc.)	EXPIRY DATE (New OHC Cards Only)
------------------------------	-------------------	--------------	---	----------------------------------

EMERGENCY NOTIFICATION INFORMATION

IN EMERGENCY NOTIFY NEXT OF KIN: (spouse, parent, etc.)		RELATIONSHIP	AREA CODE / HOME TELEPHONE
ADDRESS	CITY / TOWN	PROVINCE	AREA CODE / OTHER TELEPHONE
SECOND PERSON TO NOTIFY		RELATIONSHIP	AREA CODE / HOME TELEPHONE
ADDRESS	CITY / TOWN	PROVINCE	AREA CODE / OTHER TELEPHONE

FOR WORK RELATED INJURIES OR CONDITIONS, PLEASE COMPLETE THIS SECTION

DATE OF INJURY	NATURE OF INJURY : (Please be specific)	WORKERS COMPENSATION CLAIM NO.
SOCIAL INSURANCE NUMBER	EMPLOYER AT TIME OF INJURY	
ADDRESS OF EMPLOYER	CITY / TOWN	PROVINCE

**IF YOUR DOCTOR HAS TOLD YOU THAT YOU WILL BE STAYING OVERNIGHT IN
THE HOSPITAL AFTER YOUR SURGERY, PLEASE COMPLETE THIS SECTION.**

INPATIENT ACCOMMODATION

ACCOMMODATION REQUESTED
(YOUR ONTARIO HEALTH INSURANCE PAYS FOR WARD ACCOMMODATION ONLY)

PRIVATE : 1-BED SEMI-PRIVATE : 2-BED WARD : 4-BED

PATIENT AND / OR OTHER INSURANCE WILL PAY DIFFERENCE FOR
PREFERRED ACCOMMODATION (1 - BED, 2 - BED)

YES NO

THE HOSPITAL CANNOT GUARANTEE THAT THE ACCOMMODATION YOU REQUEST WILL BE AVAILABLE ON THE DAY OF YOUR ADMISSION.

OTHER INSURANCE

IF YOU SIGN FOR PREFERRED ACCOMMODATION AND YOUR INSURANCE DOES NOT PAY ALL OF THE EXTRA CHARGES, YOU ARE RESPONSIBLE FOR THE BALANCE. PLEASE CHECK YOUR COVERAGE BEFORE YOU COME TO THE HOSPITAL.

NAME OF INSURANCE COMPANY

NAME OF SUBSCRIBER

EMPLOYER (CARRIER FOR PREFERRED INSURANCE)

ADDRESS OF EMPLOYER

CITY / TOWN

PROVINCE

POLICY NUMBER

GROUP NUMBER

CERTIFICATE ID.

NAME OF SECOND INSURANCE COMPANY (IF ANY)

NAME OF SUBSCRIBER

EMPLOYER (CARRIER FOR PREFERRED INSURANCE)

ADDRESS OF EMPLOYER

CITY / TOWN

PROVINCE

POLICY NUMBER

GROUP NUMBER

CERTIFICATE ID.

IF YOU INTEND TO PAY ANY OF THE CHARGES WITH YOUR CREDIT CARD, PLEASE COMPLETE THE FOLLOWING.

VISA CARD
 MASTER CARD

CARD NUMBER

EXPIRY DATE

NAME AS IT APPEARS ON CARD

RCMP, ARMED FORCES PERSONNEL AND VETERANS

CURRENTLY SERVING:

SOCIAL INSURANCE NUMBER

Yes

RANK :

VETERAN :

REGIMENTAL NUMBER

BLUE CROSS ID. NUMBER

Yes

ON YOUR ADMISSION DAY, PLEASE BRING YOUR ONTARIO HEALTH CARD, OTHER INSURANCE CARDS AND YOUR VISA OR MASTERCARD IF APPLICABLE.

ALTHOUGH WE WILL TRY TO AVOID CANCELLING YOUR ADMISSION, PLEASE UNDERSTAND THAT SOMETIMES THE TOTAL NUMBER OF ADMISSIONS EXCEEDS THE NUMBER OF AVAILABLE BEDS.

NON-RESIDENTS FROM OUTSIDE CANADA MUST PAY NON-RESIDENT RATE UPON DISCHARGE. PLEASE CONTACT PATIENT ACCOUNTS OFFICE ((519) 646-6100 EXT. 66439) FOR INFORMATION.

THANK YOU FOR COMPLETING THIS FORM