

Pre-admission Form

(PLEASE PRINT CLEARLY)



RICE MEMORIAL HOSPITAL
301 Becker Avenue S.W. Willmar,
Minnesota 56201

To pre-register by phone ,
please call (320) 231-4234 or (320)
231- 4545 or 1-800-854-5093

Have you ever been a patient
at Rice Hospital before?
 Yes No Maybe

FOR CLINIC USE ONLY

Date of Admission: _____
Type of Admission: Bed Patient Same Day
Physician: _____

Demographics

_____/_____/_____
Last Name First Name Middle Name Preferred Name Social Security #

_____/_____/_____
Permanent Street Address Apt. or P.O. Box # City State Zip Code M F
Gender

(_____) - (_____) - (_____) Home Cell Work
Home Phone Cell Phone Work Phone Preferred Contact (check one)

_____/_____/_____
Date of Birth Date of Admission/Due Date Reason: Surgery Asian Black Caucasian Indian (American)
 OB Decline to answer Unknown Other _____

Married Single Widowed Divorced _____
Maiden / Other Name Name Change in Future Date of Change

Origin of Birth: Birth Country _____ Birth State: _____ Preferred Language: _____

Ethnic Group: Hispanic Non-Hispanic Primary Clinic: _____

Communication Needs? No Yes If yes, please explain. (ie. hearing aids, interpreter. etc.)

Physician

Admitting Physician or Surgeon Primary Physician & City Referring Physician

Employment

Full-Time Part-Time Not Employed Student Retired _____/_____/_____
Date of Retirement

Patient Employer Address City State Zip Code

(_____) - _____
Phone Occupation

Religion

Religion Place of Worship & City English Somali Spanish Other _____
Language

Guarantor *Complete only if different than patient* (person responsible for paying bill after insurance pays their portion)

_____/_____/_____
Last Name First Name Middle Name SSN# DOB

_____/_____/_____
Permanent Address Apt. or P.O. Box # City State Zip Code

(_____) - (_____) - (_____) Home Cell Work
Home Phone Cell Phone Work Phone Preferred Contact (check one)

Occupation Full-Time Part-Time Not Employed Retired _____/_____/_____
Date of Retirement

Emergency Contact

Primary Emergency Contact _____ Relationship to patient _____
(____) - ____ (____) - ____ (____) - ____ [] Home [] Cell [] Work
Home Phone Cell Phone Work Phone Preferred Contact (check one)
Permanent Street Address _____ Apt. or P.O. Box # _____ City _____ State _____ Zip Code _____

Secondary Emergency Contact _____ Relationship to Patient _____
(____) - ____ (____) - ____ (____) - ____ [] Home [] Cell [] Work
Home Phone Cell Phone Work Phone Preferred Contact (check one)

Insurance: (If your insurance requires prior authorization or for questions regarding out of pocket expenses, please contact your insurance co.)

Primary Insurance:
Name of Insurance _____ Member # _____ ID/Policy # _____ Group # _____
Name of Policy Holder _____ Date of Birth ____/____/____ Social Security # _____ Phone # _____
[] Full-Time [] Part-Time [] Retired [] Not Employed
Employer of policy holder (if different than patient) _____

Secondary Insurance:
Name of Insurance _____ Member # _____ ID/Policy # _____ Group # _____
Name of Policy Holder _____ Date of Birth ____/____/____ Social Security # _____ Phone # _____
[] Full-Time [] Part-Time [] Retired [] Not Employed
Employer of policy holder (if different than patient) _____

Other Insurance:
Name of Insurance _____ Member # _____ ID/Policy # _____ Group # _____
Name of Policy Holder _____ Date of Birth ____/____/____ Social Security # _____ Phone # _____
[] Full-Time [] Part-Time [] Retired [] Not Employed
Employer of policy holder (if different than patient) _____

For surgical patients only:
Have you had or scheduled a physical within 30 days prior to your admission? [] Yes [] No ____/____/____ _____
Date With whom?
What time will you be arriving at the hospital on the day of your procedure? _____
What phone number may we contact you on the day of your procedure for unexpected schedule changes (____) ____ - ____

Please call, mail or return this form prior to your scheduled visit.
If you are uninsured, have concerns about financial responsibility, or have questions regarding financial assistance programs, please call (320) 231-4371.
If you would like to receive an estimate for your out-of-pocket expenses, please call (320) 231-4234 or (320) 231-4545 or 1-800-854-5093.