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 #

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

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

____/____/____ ____/____/____ Reason: [ ] Surgery [ ] Asian [ ] Black [ ] Caucasian [ ] Indian (American)
Date of Birth Date of Admission/Due Date [ ] 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

_____ _____ [ ] English [ ] Somali [ ] Spanish [ ] Other _____
Religion Place of Worship & City 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)

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

(Over Please)

Emergency Contact

Primary Emergency Contact _____ Relationship to patient _____

Home Phone (___) ___-____ Cell Phone (___) ___-____ Work Phone (___) ___-____ [ ] Home [ ] Cell [ ] Work Preferred Contact (check one)

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

Secondary Emergency Contact _____ Relationship to Patient _____

Home Phone (___) ___-____ Cell Phone (___) ___-____ Work Phone (___) ___-____ [ ] Home [ ] Cell [ ] Work 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 # _____

Employer of policy holder (if different than patient) _____ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

Secondary Insurance:

Name of Insurance _____ Member # _____ ID/Policy # _____ Group # _____

Name of Policy Holder _____ Date of Birth __/__/__ Social Security # ___-___-____ Phone # _____

Employer of policy holder (if different than patient) _____ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

Other Insurance:

Name of Insurance _____ Member # _____ ID/Policy # _____ Group # _____

Name of Policy Holder _____ Date of Birth __/__/__ Social Security # ___-___-____ Phone # _____

Employer of policy holder (if different than patient) _____ [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Not Employed

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 (___) ___-____

For expecting mothers only:

Do you currently have a breast pump you are planning to use? [ ] Yes [ ] No

If 'No' to the question above, would you like Rice Home Medical to verify your insurance coverage for a breast pump? [ ] Yes [ ] No

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, 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.