

PRE-ADMISSION FORM

Insurance forms can be confusing and complicated. Please feel free to contact us at 850-325-5038 for assistance in filling out your pre-admission form. Once filled out please mail it back to us as soon as possible. Receiving this information will allow us to admit you for the birth of your baby in a much quicker fashion. If you would prefer to fax this information, please fax to 850-325-5148.

Name (Please Print):		
Social Security Number:		
Your Date of Birth:	Age:	
Race:	Marital Status:	
Address:		
Home Phone:		
Religious Preference:		

EMPLOYMENT INFORMATION
Employer Name:
Work Phone:
Employer Address:

PRIMARY INSURANCE

Name of Subscriber:	
Subscriber's Date of Birth:	
Insurance Address:	
Insurance Phone Number:	
Policy Number:	Group Number:
Pre-Certification Number:	Group Name:

SECONDARY INSURANCE	
Name of Subscriber:	
Subscriber's Date of Birth:	
Insurance Address:	
Insurance Phone Number:	
Policy Number:	Group Number:
Pre-Certification Number:	Group Name:
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EMERGENCY CONTACT INFORMATION

Person to contact/Next of Kin:	
Relation to the patient:	
Address:	
Home Phone:	
PATIENT INFORMATION	
Due Date:	Doctor:
Family Physician:	

CO-PAY/DEDUCTIBLE PAYMENT METHOD

- □ I plan to make a deposit on admission and pay the balance before discharge.
- □ I plan to make a deposit during pre-admission or admission and speak to a financial counselor during my stay for the balance.
- □ If uninsured, flat fee amount due in full at time of admission.

MAILING ADDRESS AND CONTACT INFORMATION

Please mail this form to:

Capital Regional Medical Center Pre-Registration 2626 Capital Medical Blvd. Tallahassee, Florida 32308

Or fax this form to us at: 850-325-5148



THE FAMILY CENTER CAPITAL REGIONAL MEDICAL CENTER

32626 Capital Medical Blvd. Tallahassee, FL 32308 850-325-5000 www.capitalregionalmedicalcenter.com