

PATIENT INFORMATION

Last Name		First Name	Middle Initial	Maiden Name
Date of Birth	County & State of Patient's Birth		Sex	Social Security Number
Street/Address		City	State	Zip Code
County	Home Telephone	Marital Status S M W D Sep		Race
Ever Been A Patient at SMH? Yes <input type="checkbox"/> No <input type="checkbox"/>		Patient's Employer	Employer's Address	
Employer's Telephone		Patient's Occupation	Patient Ever Served in Armed Services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does Patient Smoke?	Religious Affiliation		Church You Attend	

WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY OTHER THAN SPOUSE?

Name	Relation to Patient	Address	Telephone (Day)	Telephone (Night)
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SPOUSE DEMOGRAPHICS

iName- LAST, FIRST, MI	Street Address	City	State	Zip Code
Telephone	Social Security Number	Date of Birth	Place of Birth	
Employer	Employer's Address	Employer's Telephone	Occupation	
Has Patient been Hospitalized in Past 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, Name and Location of Hospital	Dates Hospitalized	

INSURANCE INFORMATION

Name of Insurance Company		Insured's Name As On Insurance Card		
Address to Mail Claims (see Insurance Card)		Effective Date of Insurance		
Contract Number	Group Number	Relation to Patient		
Name of Insurance Company		Insured's Name As On Insurance Card		
Address to Mail Claims (see Insurance Card)		Effective Date of Insurance		
Contract Number	Group Number	Relation to Patient		

Additional Insurance Information:

PROCEDURE INFORMATION

Anticipated Date To Enter Hospital or Scheduled Procedure	Ordering Physician's Name
Being Hospitalized for: Inpatient Outpatient Other (Please specify) _____	

MATERNITY PATIENTS ONLY

Pediatrician's Name
Additional Comments:

IT IS EXTREMELY IMPORTANT THAT YOU BRING YOUR DRIVER'S LICENSE, INSURANCE ID CARDS AND PHYSICIAN ORDERS AT THE TIME OF YOUR SERVICE.

Please feel free to contact the Pre-Registration Office at 251-460-5240 at any time between the hours of 7:00a.m. and 5:00p.m., if you have any questions about your registration or if we may be of assistance to you in completing this form.

Mail completed form to:

SPRINGHILL MEMORIAL HOSPITAL
 Confidential Information
 ATTN: Pre-Registration Office
 P.O. Box 8246
 Mobile, AL 36689-9981

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