PeaceHealth
Southwest Medical Center

PRE-REGISTRATION PATIENT QUESTIONNAIRE

NOTE: If you plan to enter the hospital within the next 48 hours, please call Pre-Registration with the following information:

MEDICAL CENTER CAMPUS
360 / 514-2099

MATERNITY – MEDICAL CENTER CAMPUS
360 / 514-2429

MEMORIAL CAMPUS
360 / 696-5135

HOSP. INFO.

EXPECTED DATE OF ARRIVAL / /	EXPECTED TIME OF ARRIVAL AM PM	WHO IS YOUR PRIMARY CARE PHYSICIAN	YOUR SURGEON AND/OR OB-GYN	TYPE OF SERVICE ❑ SURGERY ❑ MATERNITY ❑ OTHER

MATERNITY

ESTIMATED DUE DATE / /	OBSTETRICIAN/NURSE MIDWIFE	CLINIC'S NAME	WHO IS YOUR PRIMARY CARE PHYSICIAN	BABY'S DOCTOR

PATIENT INFORMATION

PATIENT'S NAME	LAST	FIRST FULL LEGAL NAME	MIDDLE INITIAL	PATIENT'S MOTHER'S MAIDEN NAME
ADDRESS	STREET	CITY	STATE / ZIP CODE	SOCIAL SECURITY NO.

PATIENT'S TELEPHONE ( )	PATIENT'S CELL PHONE ( )	BIRTHDATE	AGE	SEX	RELIGIOUS PREFERENCE	PARISH OR CHURCH

EMAIL	RACE	ETHNICITY

LANGUAGE	INTERPRETER SERVICE AND/OR SPECIAL ACCOMMODATIONS PROVIDED: ❑ NOT NEEDED ❑ YES _____

SPOUSE OR PARENT'S NAMES	MARITAL STATUS (CHECK ONE) ❑ SINGLE ❑ WIDOWED ❑ MARRIED ❑ DIVORCED ❑ SEPARATED

RESPONSIBILITY

NAME OF PERSON ASSUMING FINANCIAL RESPONSIBILITY FOR ABOVE (PARENT OR GUARDIAN)	GUARANTOR'S BIRTHDATE

TELEPHONE	ADDRESS OF RESPONSIBLE PARTY

HUSBAND / FATHER'S SOCIAL SECURITY NO.	WIFE / MOTHER'S SOCIAL SECURITY NO.

EMPLOYMENT INFORMATION

PATIENT'S OCCUPATION (OR FATHER IF MINOR)	EMPLOYER'S COMPANY OR BUSINESS NAME	DATE EMPLOYED	FULL TIME ❑ YES ❑ NO

EMPLOYER'S ADDRESS	EMPLOYER'S TELEPHONE / EXT.	PAGER OR CELL PHONE NO.

HUSBAND'S / WIFE'S OCCUPATION (OR MOTHER IF MINOR)	EMPLOYER'S COMPANY OR BUSINESS NAME	DATE EMPLOYED	FULL TIME ❑ YES ❑ NO

EMPLOYER'S ADDRESS	EMPLOYER'S TELEPHONE / EXT.	PAGER OR CELL PHONE NO.

INSURANCE INFORMATION

NAME YOUR PRIMARY INSURANCE COMPANY	ADDRESS OF PRIMARY INSURANCE	TELEPHONE NO.	MY INSURANCE IS THROUGH ❑ EMPLOYMENT ❑ PRIVATE

POLICY MEDICARE NO. / UNION AND LOCAL	GROUP NO. & GROUP NAME	THROUGH WHOSE EMPLOYMENT IS THIS INSURANCE CARRIED? ❑ SELF ❑ SPOUSE ❑ PARENT

NAME ADDITIONAL INSURANCE CO.	ADDRESS OF INSURANCE COMPANY	TELEPHONE NO.	ADDITIONAL INSURANCE IS THROUGH ❑ EMPLOYMENT ❑ PRIVATE

POLICY MEDICARE NO. / UNION AND LOCAL	GROUP NO. & GROUP NAME	THROUGH WHOSE EMPLOYMENT IS ADDITIONAL INSURANCE CARRIED? ❑ SELF ❑ SPOUSE ❑ PARENT

ACCIDENT INFORMATION

DATE OF INJURY	TIME OF INJURY	HOW ACCIDENT HAPPENED

WHERE ACCIDENT HAPPENED

❑ WORK RELATED ❑ AUTO ACCIDENT ❑ OTHER _____

FRIEND OR RELATIVE

NAME OF LOCAL FRIEND OR RELATIVE OTHER THAN LISTED ABOVE	RELATIONSHIP
ADDRESS	TELEPHONE

I have a: ❑ Living Will / Advance Directive

Has the patient ever received services at the Medical Center? ❑ Yes ❑ No If yes, under what name: _____

Does patient have any allergies to food or medications? ❑ Yes ❑ No If yes, please list: _____

_____