El Camino Health

2500 Grant Road, Mountain View, CA 94040-4378
815 Pollard Road, Los Gatos, CA 95032

EL CAMINO HOSPITAL

Please complete and return form to Patient Registration prior to the date you are to enter the hospital

PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARDS OR BRING THEM WITH YOU ON ADMISSION

Patient Registration Department: Mountain View 650-940-7111

PRE-ADMISSION RECORD

PATIENT INFORMATION

Date To Enter Hospital	Physician	Primary Care Physician (PCP)	Notify PCP on Admission? ☐ Yes ☐No	Maternity ☐ Yes ☐ No	Due Date / /	Maiden Name: Previous Name:	I authorize the hospital to verify my insurance benefits for this hospital service. ☐ Yes ☐ No Signature _____

Patient's Legal Name (Last, First, Middle)	Place of Birth	Date of Birth	Age	Sex	Marital Status	Religious Preference	Social Security Number

Patient's Address (Street, City, State, Zip Code)	Email Address	Patient's Home Phone

Patient's Employer	Occupation	Patient's Work Address (Street, City, State, Zip Code)	Patient's Work Phone

Name of Emergency Contact	Address (Street, City, State, Zip Code)	Home Phone	Work Phone	Relationship to Patient

Name of Person Responsible for Hospital Bill (if other than patient)	Address (Street, City, State, Zip Code)	Home Phone	Relationship to Patient

Ethnicity ☐ Hispanic ☐ None-Hispanic	Principal Language Spoken:	Race *The State requires hospital to collect statistical information on* Race and Ethnicity. *Providing this information is voluntary.* ☐ White ☐ Black ☐ Asian / Pacific Islander ☐ Native American / Eskimo ☐ Other _____

INSURANCE COVERAGE INFORMATION

PRIMARY INSURANCE — EMP STATUS: ☐ FT ☐ PT ☐ DISABLED ☐ RETIRED

Insurance Company Name	Identification Number	Group Number	Subscriber's Name	Subscriber's Employer	Work Phone

Subscriber's Birthdate	Subscriber's Sex	Subscriber's Social Security Number:	Patient's Relationship to Subscriber:

SECONDARY OR SUPPLEMENTAL INSURANCE

Insurance Company Name	Identification Number	Group Number	Subscriber's Name	Subscriber's Employer	Work Phone

Subscriber's Birthdate	Subscriber's Sex	Subscriber's Social Security Number:	Patient's Relationship to Subscriber:

WORK RELATED INJURY

Employer at Time of Injury	Employer's Address (Street, City, State, Zip Code)	Employer's Work Phone	Date of Injury

Industrial Insurance Name	Industrial Insurance Address (Street, City, State, Zip Code)	Ind Insur Phone Number	Claim Number (if known)

CHAMPUS

Patient is a: ☐ Spouse ☐ Child ☐ Retiree	Card Number	Effective Date:	Expiration Date:	Name of Sponsor (Last, First, Middle)	Service Number	Grade

Social Security Number	Organization & Duty Station (Home Port/Retiree's Address)	Branch of Service ☐ USA ☐ USAF ☐ USMC ☐ USN ☐ USCG ☐ USPHS ☐ EESA	Status: ☐ Active Duty ☐ Retired ☐ Deceased

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