KATZ Women's Hospital | North Shore University Hospital

MATERNITY PRE-ADMISSION QUESTIONNAIRE

PATIENT INFORMATION –PLEASE PRINT CLEARLY

Attending Physician Name (Do Not Provide Group Name)		Anticipated Admit Date	Date of Last Menstruation	Medical Record Number
Last Name	First Name	Middle Name	Maiden Name	AKA
Address	Apt	City	State	Zip Code
Home Telephone ( )	Alt/Cell Phone ( )		Email Address	
Date of Birth (month in words/dd/yyyy)			Social Security No.	
Marital Status	Race	Religion	Veteran Y/N	Birth place (City, State)
Patient's Mother (First name only)	Patient's Father (First name only)			
Occupation	Employer's Name			
Employer Address		Employer Telephone No		
Name of Next of Kin		Relationship to patient		
Address	City	State	Zip	Home Phone	Wk Phone	Cell Phone
Name of Emergency Contact (if different than Next of Kin)		Relationship to patient		
Address	City	State	Zip	Home Phone	Wk Phone	Cell Phone

THE GUARANTOR IS THE PERSON RESPONSIBLE FOR PATIENT'S BILL

Guarantor's Information	Last Name	First Name	Relationship to patient	Date of Birth		Social Security No
	Address	City	State	Zip	Home Phone	Wk Phone	Cell Phone
	Occupation	Employer Name		Employer Telephone No		

Primary Insurance Insurance through current employer Y/N _____ Insurance through previous employer Y/N _____	Name of Insurance Company Address Telephone No.		Policy #
	Policyholder Name	Policyholder DOB	Policyholder Social Security No.
	Employer Name:	Employer Phone No.	
Secondary Insurance Insurance through current employer Y/N _____ Insurance through previous employer Y/N _____	Name of Insurance Company Address Telephone No.		Policy #
	Policyholder Name	Policyholder DOB	Policyholder Social Security No.
	Employer Name	Employer Phone No.	

PLEASE ATTACH COPIES (Front and Back) OF ALL INSURANCE CARDS

Pediatrician Last Name , First Name	Pediatrician Address and Phone No

KATZ Women's Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION BY NORTH SHORE UNIVERSITY HOSPITAL

1. Insurance Companies and Third Party Payers

I hereby authorize and direct North Shore University Hospital (NSUH), having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____ X _____

Date — Signature of Patient or Authorized Representative

2. Discharge Planning Services

In the event that I require post-hospital services upon my discharge from NSUH, I hereby authorize NSUH to release medical record information, including my (the patient's) medical record, portions thereof or information therefrom (as it deems appropriate), to providers of post-hospital care services, including but not limited to residential health care facilities and home care agencies, for the purpose of facilitating necessary discharge planning arrangements.

_____ X _____

Date — Signature of Patient or Authorized Representative

3. Assignment to NSUH

I hereby assign, transfer, and set over to NSUH sufficient monies and / or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

_____ X _____

Date — Signature of Insured or Authorized Representative

4. Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization furnishing the services to submit a claim to Medicare for payment to me.

_____ X _____

Date — Signature of Patient or Authorized Representative

5. For Person Guaranteeing Patient's Bill

For, and in consideration of, services rendered or to be rendered to the patient named herein by NSUH, I hereby guarantee payment of any and all bills rendered for said patient which are not covered or allowed by the carrier.

Date: _____ Signed: X _____

Witness: _____ Relationship: X _____

North Shore LIJ

HOSPITAL INPATIENT DIRECTORY REQUEST

PATIENT NAME (PRINT): _____ **DATE OF BIRTH:** _____

☐ **INCLUDE PATIENT'S NAME AND LOCATION IN THE HOSPITAL INPATIENT DIRECTORY (OPT-IN)**
I understand that the patient's room location will be released to people who ask for the patient by name.

☐ **DO NOT INCLUDE PATIENT'S NAME AND LOCATION IN THE HOSPITAL INPATIENT DIRECTORY (OPT-OUT)**
I understand that the patient's name and location in the hospital will not be disclosed to anyone who asks for the patient by name unless required by law.

I understand that the patient request only applies to the patient's current inpatient stay at this hospital and that the patient can change their mind at any time during the inpatient stay at this hospital.

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # OR			
Signature: Interpreter		Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date / Time	Print Name	

REVOCATION TO ABOVE REQUEST

PATIENT NAME (PRINT): _____ **DATE OF BIRTH:** _____

☐ **THE PATIENT REVOKES THE ABOVE REQUEST. PLEASE CHANGE THE PATIENT'S ORIGINAL HOSPITAL INPATIENT DIRECTORY REQUEST.**

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # OR			
Signature: Interpreter		Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date / Time	Print Name	

NOTE FOR FACILITY USE ONLY

☐ ADMITTING NOTIFIED TO MAKE CHANGE REQUEST

NAME OF ADMITTING STAFF CONTACTED _____ **DATE** _____

NAME OF REQUESTOR _____ **DATE** _____

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Copy 1 – Patient Medical Record **Copy 2** – Admitting **Copy 3** – Patient or Patient's Personal Representative