



TO ASSIST YOUR  
ADMISSION  
PLEASE FILL IN THE  
ENTIRE FORM  
INCLUDING THE  
SHADED AREAS.

**PRE-ADMISSION INFORMATION**

EXPECTED ADMISSION DATE

NAME OF PHYSICIAN

NAME OF MIDWIFE

<b>PATIENT'S NAME AND ADDRESS</b>	PATIENT'S NAME (LAST, FIRST MIDDLE)		MAIDEN		MOTHER'S FIRST NAME	
	ADDRESS		CITY	STATE	ZIP PHONE	
<b>EMPLOYMENT DATA</b>	PATIENT'S OCCUPATION (CURRENT)		EMPLOYERS NAME AND ADDRESS (CURRENT) *IF RETIRED OR UNEMPLOYED ENTER LAST JOB & EMPLOYER			
	HUSBAND'S OR WIFE'S OCCUPATION		EMPLOYERS NAME AND ADDRESS			
<b>PATIENT IDENTIFICATION</b>	AGE	DATE OF BIRTH	PLACE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	NAME OF HUSBAND OR WIFE	
	ARE YOU A U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU A VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO	SS#	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP.	RELIGION - CHURCH OR SYNAGOGUE	
	HAVE YOU BEEN TREATED AT ST. MARY'S HOSPITAL BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES - APPROXIMATE DATE	NAME AT THAT TIME <input type="checkbox"/> SAME <input type="checkbox"/> (PLEASE SPECIFY)			
	PLEASE CHECK OFF HOSPITAL DEPARTMENT WHERE TREATED <input type="checkbox"/> INPATIENT <input type="checkbox"/> EMERGENCY RM <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> CLINIC <input type="checkbox"/> LAB <input type="checkbox"/> X-RAY <input type="checkbox"/> OTHER			PLEASE SPECIFY	PLEASE CHECK OFF SMOKING STATUS <input type="checkbox"/> SMOKER <input type="checkbox"/> EX SMOKER <input type="checkbox"/> NEVER SMOKED	
<b>EMERGENCY CONTACT</b>	NAME OF NEAREST LIVING RELATIVE				RELATIONSHIP	
	ADDRESS				PHONE NO.	
<b>MEDICAL INSURANCE</b>	NAME OF PRIMARY INSURANCE CO.			SUBSCRIBER'S NAME & DATE OF BIRTH		
	ADDRESS OF INSURANCE CO.			GROUP #	POLICY NUMBER	
	NAME OF EMPLOYER		DEPT.	CO-PAY /ANNUAL DEDUCTIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT _____		
	ADDRESS OF EMPLOYER					
	CITY		STATE	ZIP	PHONE	
	NAME OF SECONDARY INSURANCE CO.			SUBSCRIBER'S NAME & DATE OF BIRTH		
	ADDRESS OF INSURANCE CO.			GROUP #	POLICY NUMBER	
	NAME OF EMPLOYER		DEPT.	CO-PAY /ANNUAL DEDUCTIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO AMOUNT _____		
ADDRESS OF EMPLOYER						
CITY		STATE	ZIP	PHONE		
<b>WORKERS COMPENSATION</b>	NAME OF EMPLOYER AT TIME OF INJURY		EMPLOYER ADDRESS			
	NAME OF INSURANCE CARRIER		INSURANCE CO ADDRESS			
	PHONE NUMBER	CONTACT NAME				
<b>FINANCIAL RESPONSIBILITY</b>	NAME OF PERSON FINANCIALLY RESPONSIBLE		RELATIONSHIP	PHONE		
	STREET ADDRESS		CITY	STATE	ZIP	
	HOW DO YOU PAY FOR SERVICES NOT COVERED BY INSURANCE?					
<b>MATERNITY ADMISSIONS</b>	EXPECTED DUE DATE		NAME OF PEDIATRICIAN			

If you are uninsured or otherwise unable to pay all or part of your medical bill, you may qualify for financial assistance. If you would like to determine your eligibility for this program, one of our Financial Counselors will be glad to assist you. They may be contacted at 203-709-7741.

**PLEASE BRING INSURANCE CARDS AND PHOTO IDENTIFICATION ON DAY OF ADMISSION**