

PLEASE COMPLETE FORM IN FULL AND RETURN IMMEDIATELY

Lenox Hill Hospital

PRE-ADMISSION INFORMATION

OBSTETRICS:

Anticipated Due Date: _____ / _____ / _____

Physician's Name: _____

PATIENT INFORMATION

Name: _____
Last First

Address: _____
Street Apt# City State Zip

County of Residence: _____ Phone () _____ Social Security # _____

RACE:
 Asian Black White
 Hispanic American Indian

SEX: Male Female

MARITAL STATUS:
 Married Widowed
 Single Divorced
 Separated

DATE OF BIRTH

Month | Day | Year

Mother's Maiden Name _____

Patient's Maiden Name _____

Place of Birth
 City State Country

Are you an employee of Lenox Hill Hospital? Yes No

Religion _____

Do You Carry An Organ Donor Card? Yes No

Occupation _____

Employer _____

Employer Address Street _____

City State Zip _____

Length of Service With Current Employer Years Months

Employer's Phone () _____

EMPLOYMENT STATUS
 Employed Disabled
 Unemployed Retired

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS

Name of Person on Insurance Card _____ Relationship to Patient _____
Last First

Address Street Apt# City State Zip _____

County of Residence _____ Phone # () _____ Social Security # _____

Employment Status Employed Unemployed Disabled Retired Sex Male Female Date of Birth _____

Occupation _____ Employer _____

Employer Address Street City State Zip Phone () Ext: _____

PERSON TO CONTACT IN AN EMERGENCY

Relationship to Patient _____

Name: Last _____ First _____

Address: Street Apt # City State Zip _____

Home Phone: () _____ Work Phone: () _____ Ext: _____

IF PATIENT IS 18 OR UNDER (25 IF STUDENT) ENTER OTHER PARENT INFORMATION BELOW.
 IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION. OTHERWISE ENTER CLOSEST RELATIVE.

LEGAL NEXT OF KIN

Relationship to Patient _____ Date of Birth _____

Name: Last _____ First _____

Address: Street Apt # City State Zip _____

Home Phone: () _____ Work Phone: () _____ Ext: _____

MISCELLANEOUS

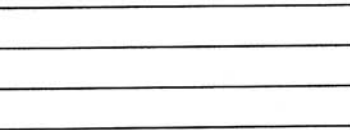
Have you ever been an inpatient at Lenox Hill Hospital? Yes No

If yes, under what name? _____ **Dates: From: Mo Day Yr To: Mo Day Yr**

Have you been an inpatient in another hospital or skilled nursing facility within the last 60 days? Yes No

If yes, under what name? _____ **Dates: From: Mo Day Yr To: Mo Day Yr**

Name of Institution: _____



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IN THE
UNITED STATES



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ADMISSIONS DEPARTMENT
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New York, NY 10131-0072

