

PRE-ADMISSION INFORMATION



BROWARD HEALTH
Coral Springs Medical Center

3000 Coral Hills Drive
Coral Springs, Florida 33065
Phone: 954-344-3226 • Fax: 954-344-3307

Today's Date _____
Expected Delivery Date _____
Doctor Admitting you _____
C Section _____

PATIENT INFORMATION

Patient's Name _____
LAST NAME FIRST NAME MIDDLE INITIAL

Patient's Maiden or Previous Name _____
LAST NAME FIRST NAME MIDDLE INITIAL

Permanent Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

Phone Number _____ Own or rent? _____ How long? _____

Local Address (if different than Permanent Address) _____ Apt. No. _____

City _____ Zip Code _____ Phone No. _____

Marital Status _____ Age _____ Date of Birth _____

Birthplace _____ Admitted to this hospital before? _____ When? _____

Under what name were you admitted before? _____

Religion _____ Church _____

Employer's name & address _____

Occupation _____ Phone _____ Social Security No. _____

SPOUSE/BLOOD RELATION/NEXT-OF-KIN INFORMATION

Name _____ Relationship _____ Date of Birth _____ SS # _____

Address _____ Apt. No. _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Employer's name & address _____ Name of person to be contacted

in an emergency if the above is not available _____ Relationship/Phone _____

FINANCIAL INFORMATION

Person responsible for this bill _____ Relationship _____

Address _____ Phone _____

Employer's name & Address _____

Occupation _____ How long? _____ Phone _____

Social Security Number of responsible party _____

Please turn this form over and complete the back section. Thank you.

INSURANCE INFORMATION

Primary Insurance name _____
Company holding insurance _____
Policy holder's name _____ Relationship to patient _____
Insurance Company Address _____
Policy number _____ Group number _____
Insurance Company Phone Number _____

Secondary Insurance name _____
Company holding insurance _____
Policy holder's name _____ Relationship to patient _____
Insurance Company Address _____
Policy number _____ Group number _____
Insurance Company Phone Number _____

Will baby be covered under same insurance as mother? Yes No

If you provide no insurance information please contact our offices immediately so that we can make the necessary payment arrangements. If you have insurance coverage, please attach a photocopy of the FRONT and BACK of all insurance cards, before returning this form to us. If you have any questions regarding your pre-registration, please contact the admitting office, 344-3226.