Irwin County Hospital

Patient Pre-Registration Form

For Office Use Only:

MRUN: _____
Visit #: _____
Registrar: _____

Please **print** and complete all questions, and include a copy of your legal ID and all insurance cards (front and back).

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial		Type of Care: ☐ In Patient ☐ Same Day Surgery ☐ Maternity ☐ Surgery ☐ Out Patient (Pain, Endoscopy)	
Race	Marital Status	Religion	Primary Language	Date of Birth (mm/dd/yyyy)	Date of Scheduled Visit
Physician's Last Name	First Name			☐ Female ☐ Male	Social Security No.
Patient's Street Address	Apt. No.			City	State / Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )		Visit Reason or Diagnosis	For OB patients: Last Menstrual Period:
Temporary Address	Apt. No.			City	State / Zip
Patient's Current Employer Name	Employer Address			City	State / Zip
Employer Phone ( )	Patient's Occupation			Employment Status: ☐ Not Employed ☐ Full Time ☐ Part Time ☐ Student ☐ Retired and Date:	
Full Name of Emergency Contact	Relationship			Home Phone ( )	Work Phone ( )
Have you ever been a patient at Irwin County Hospital? ☐ Yes ☐ No				If yes, when was your last visit?	Under what name?

Guarantor or person responsible for bill

Last Name	First	Middle Initial		Relationship	Date of Birth (mm/dd/yyyy)
Street Address	Apt. No.			☐ Female ☐ Male	Marital Status / Social Security No.
City	State	Zip	Home Phone ( )	Work Phone ( )	Cell Phone ( )
Employer Name	Employer Address			City	State / Zip
Employer Phone ( )	Occupation			Employment Status: ☐ Not Employed ☐ Full Time ☐ Part Time ☐ Student ☐ Retired and Date:	

Insurance Information

Primary Insurance Name				Name of Insured exactly as appears on card	
Insurance Billing Address	City	State	Zip	Phone No. ( )	
Policy No. (for BCBS, include 3 letter prefix)	Group No.	Plan Code	State	Effective Date	Expiration Date
Subscriber's Full Name	Subscriber's Soc. Sec. No.		Subscriber's Date of Birth (mm/dd/yyyy)	☐ Female ☐ Male	
Subscriber's Employer name (if self-employed, company name)	Relation to Insured		Subscriber's Employment Status: ☐ Not Employed ☐ Full Time ☐ Part Time ☐ Student ☐ Retired and Date:		
Subscriber's Employer Address	City	State	Zip	Phone No. ( )	

Insurance Information

Medicare Number	Patient's name as appears on card		Effective Date (mm/dd/yyyy)	□ Part A (Hospital Benefit) □ Part B (Medical Benefit)	
Medicaid Number	Patient's name as appears on card		Effective Date	State	
Secondary Insurance Name			Name of Insured exactly as appears on card		
Insurance Billing Address	City	State	Zip	Phone No. ( )	
Policy No. (for BCBS, include 3 letter prefix)	Group No.	Plan Code	State	Effective Date	Expiration Date
Subscriber's Full Name	Subscriber's Soc. Sec. No.		Subscriber's Date of Birth (mm/dd/yyyy)	□ Female □ Male	
Subscriber's Employer name (if self-employed, company name)	Relation to Insured		Subscriber's Employment Status: □ Not Employed □ Full Time □ Part Time □ Student □ Retired and Date:		
Subscriber's Employer Address	City	State	Zip	Phone No. ( )	

Worker's Compensation

Is this visit the result of an accident? □ Yes □ No	□ Employment □ Automobile □ Other	Date of Accident: (mm/dd/yyyy)	Claim No.
Letter of Authorization □ Yes □ No	Claim Adjuster / Contact Name	Phone No. ( )	Insurance Name
Insurance Address	City	State	Zip Phone No. ( )

Advance Directive

Do you have an Advance Directive, such as a Living Will or Durable Power of Attorney for Health Care? □ Yes □ No
Please specify the type: _____
*** *If yes, please bring a copy at the time of your admission****

Self-Pay

* If insured but your procedure is not covered or verified by your plan, a deposit is required at the time of admission. Please contact *Admissions Department at 229-468-3800* for details before your scheduled arrival date.

* If you do not have insurance, please call our *Financial Counselors at 229-468-3800* before your scheduled arrival date to discuss financial options including our Community Assistance Program which is available based on financial need eligibility.

Additional Information

Do you need special accommodations, such as Translation, Visual Aid, etc.? □ Yes □ No

*** If yes, please specify so that prior arrangements can be made for the day of your visit. ***

□ Language Interpreter _____ □ Sign Language Interpreter □ Visual aid □ Other: _____

Please fax or mail completed form with a copy of your insurance cards (front and back) at least one week prior to your admission.

Mailing address:
Irwin County Hospital
Admissions Department
710 N Irwin Ave
Ocilla, GA 31774

Fax Number:
(229) 468-3897
Attention: Shyea Courson