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. _____

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SPOUSE/BLOOD RELATION/NEXT-OF-KIN INFORMATION

Date of Birth_____
Name__________ Relationship_____ 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 _____

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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.

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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.