CEDARS-SINAI MEDICAL CENTER

Admissions

PRE-ADMISSION FORM

HOSPITAL USE ONLY

Hospital Service	Admitting Diagnosis	Surgical Procedure	Exp. Length of Stay	Case Medical Record Number

PLEASE DO NOT WRITE ABOVE THIS LINE.

INSTRUCTIONS:

1. Please print clearly and complete all information on both sides.
2. If you request a super deluxe room, please see page 3 of your Pre-Admission book.
3. If you require assistance in completing this form, please call your service department.
4. Please furnish a copy of your insurance card (front and back), as applicable.
5. Upon completion, please insert this form in the enclosed postage paid envelope and mail.
6. Please remember to bring your insurance identification card when you come to be admitted.
7. If you are a maternity patient, list obstetrician and pediatrician below.

PLEASE RETURN TO:

Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, CA 90048-1869

Attention: Pre-Admissions

PATIENT TO COMPLETE

NAME OF ATTENDING PHYSICIAN	TELEPHONE NUMBER OF PHYSICIAN	NAME OF OTHER PHYSICIAN	TELEPHONE NUMBER OF PHYSICIAN	EXPECTED DATE OF ADMISSION

NAME OF PATIENT (LAST NAME, FIRST NAME, MIDDLE INITIAL)	BIRTHDATE	SEX	ETHNIC GROUP
		❒ M ❒ F	❒ Caucasian ❒ Black ❒ Asian ❒ Hispanic ❒ Native American ❒ Other

NAME USED IF PREVIOUSLY REGISTERED	DRIVER'S LICENSE NUMBER	STATE	MARITAL STATUS	RELIGIOUS PREFERENCE
			❒ M ❒ S ❒ W ❒ D ❒ DP	

ADDRESS (NUMBER, STREET, CITY, SATE, ZIP CODE)	HOME TELEPHONE

MAIDEN NAME	MOTHER'S MAIDEN NAME	SOCIAL SECURITY NUMBER	BIRTHPLACE (CITY, STATE, COUNTRY)

OCCUPATION	EMPLOYER	ADDRESS OF EMPLOYER (NUMBER, STREET, CITY, STATE, ZIP CODE)	EMPLOYER'S TELEPHONE NUMBER

SPOUSE OR RESPONSIBLE PARTY

NAME OF SPOUSE OR RESPONSIBLE PARTY (LAST NAME, FIRST NAME, MIDDLE INITIAL)	RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER

ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER

OCCUPATION	EMPLOYER	ADDRESS OF EMPLOYER (NAME, STREET, CITY, STATE, ZIP CODE)	SOCIAL SECURITY NUMBER

NEAREST LOCAL RELATIVE OR FRIEND

NAME OF NEAREST LOCAL RELATIVE OR FRIEND (LAST NAME, FIRST NAME, MIDDLE INITIAL)	RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER

ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER

INSURANCE INFORMATION

METHOD OF PAYMENT ❒ CASH ❒ HOSPITAL INSURANCE	MEDICARE NUMBER	HOSPITAL EFFECTIVE DATE	MEDICAL EFFECTIVE DATE	IF CO-INSURANCE IS MEDICAL, ENTER MEDICAL NO.

❒ BLUE CROSS: STATE ❒ BLUE SHIELD →	GROUP NUMBER	CERTIFICATE/SUBSCRIBER NUMBER F	COVERAGE CODE	EFFECTIVE DATE

NAME OF SUBSCRIBER	RELATIONSHIP OF SUBSCRIBER TO PATIENT	NAME OF POLICY HOLDER

❒ ROSS-LOOS/CIGNA →	GROUP NUMBER	MEMBER NUMBER	FAMILY NUMBER	CLINIC NAME

NAME OF SUBSCRIBER	RELATIONSHIP OF SUBSCRIBER TO PATIENT	NAME OF POLICY HOLDER

☒ OTHER INSURANCE →	NAME OF OTHER INSURANCE COMPANY	GROUP/POLICY/UNION LOCAL NUMBER	OTHER I.D. NUMBER	EFFECTIVE DATE

NAME OF POLICY HOLDER	RELATIONSHIP OF SUBSCRIBER TO PATIENT	TELEPHONE NUMBER/ADDRESS FOR INSURANCE VERIFICATION

WORKERS COMPENSATION

IS THIS ADMISSION COVERED BY WORKERS COMPENSATION? ❒ YES ❒ NO	NAME AND ADDRESS OF COMPANY

NAME OF ADJUSTER	DATE OF INJURY	CLAIM/FILE NUMBER	TELEPHONE NUMBER OF ADJUSTER ( )

NAME AND ADDRESS OF EMPLOYER AT TIME OF INJURY	TELEPHONE NUMBER OF EMPLOYER ( )

Does your insurance require a second option? ❒ YES ❒ NO	If yes, did you obtain a second option? ❒ YES ❒ NO	If yes, please forward a copy with this form or bring it when admitting.
Does your insurance require pre-review? ❒ YES ❒ NO	If yes, has the pre-review been approved? ❒ YES ❒ NO	IF YES, PRE-REVIEW REFERENCE NUMBER

NAME AND ADDRESS OF PRE-REVIEW ORGANIZATION	TELEPHONE NUMBER OF PRE-REVIEW ORGANIZATION ( )

OTHER INFORMATION

Do you anticipate that you will need assistance upon discharge from the hospital? ❒ YES ❒ NO	Admitted Alone? ❒ YES ❒ NO

Are you being admitted from a ❒ House ❒ Apartment ❒ Skilled Care Facility ❒ Convalescent Home ❒ Other (please specify)

AUTHORIZATION TO VERIFY INSURANCE COVERAGE

I hereby authorize Cedars-Sinai Medical Center to contact my Insurance Company to verify my Insurance Coverage.

SIGNATURE OF PATIENT	DATE SIGNED	SIGNATURE OF INSURED PARTY	DATE SIGNED

NOTES