

Pre-Admission Form Instructions for Printing and Mailing

Print pages.

Fill out the Pre-admission Form completely.

Place the back of the form to the back of the address page.

Fold the two pages so that our address shows on the outside.

Tape or staple closed, and mail.

Pre-admission Form

Thank you for your prompt pre-registration! If you have any questions, please call (678) 442-3600.

Patient Information

Patient's Name: _____
Date of Birth: ____ / ____ / ____ SS#: _____ - _____ - _____ Race: _____ Marital Status: _____
Home Address: _____
City: _____ State: _____ Zip: _____ County of Residence: _____
Home Telephone:() _____ Work Telephone:() _____
Occupation: _____ Employer: _____
Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Information

Spouse's Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____ County of Residence: _____
Home Telephone:() _____ Work Telephone:() _____
Occupation: _____ Employer: _____
Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Information *Whom should we notify in case of an emergency?*

Name: _____
Relationship to You: _____ Telephone:() _____
Address: _____ City: _____ State: _____ Zip: _____

Guarantor Information (Responsible Party) *(If same as patient information, check here: •)*

Guarantor's Name: _____ Relationship to You: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone:() _____ Work Telephone:() _____
Employer: _____ Employer Address: _____

Insurance Information *Please bring all insurance cards when you come to the Women's Pavilion.*

Do you have insurance coverage? • yes • no

Primary Insurance

Company Name: _____
Address: _____
Telephone:() _____
Contract/Policy#: _____ Group#: _____
Insured's Name: _____
Insured's Birthdate: ____ / ____ / ____
Insured's Relationship to You: _____
Insured's Social Security#: ____ - ____ - _____

Secondary Insurance

Company Name: _____
Address: _____
Telephone:() _____
Contract/Policy#: _____ Group#: _____
Insured's Name: _____
Insured's Birthdate: ____ / ____ / ____
Insured's Relationship to You: _____
Insured's Social Security#: ____ - ____ - _____

Miscellaneous Information

Have you ever been a patient at Gwinnett Medical Center or Gwinnett Women's Pavilion? _____ When? _____
_____ What was your name then? _____ Expected due date: ____ / ____ / ____
Obstetrician's Name: _____ *Pediatrician's Name: _____

**If you plan to use our on-call/in-house pediatrician, please contact your insurance carrier to insure coverage.*

Please attach copy of front and back of insurance cards, fold form on the dotted lines so that our address shows on the outside, tape or staple closed, and mail.

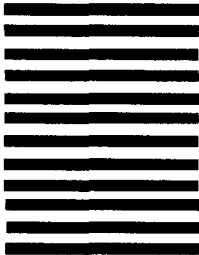


BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 69 LAWRENCEVILLE, GA

POSTAGE WILL BE PAID BY ADDRESSEE

THE GWINNETT WOMEN'S PAVILION
Attention: Business Office
P.O. Box 348
Lawrenceville, Georgia 30046-9829

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



PREADMISSION INFORMATION ENCLOSED

