Confidential Pre-Registration Record

Instructions:

Please complete this form and return to Capital Medical Center immediately. For your convenience you may fax this form *to (360)704-4704* or mail to:

Capital Medical Center
Attention: Admitting Department
3900 Capital Mall Dr. SW
Olympia, Washington 98502

Please include a copy of all insurance cards (front & back) or Medicaid coupons. If you do not have a copy of your insurance to provide, please be sure to bring that with you at the time of admission. We can copy your insurance card and picture ID at that time. You will also be asked to sign a consent form at that time. If you have any questions, please feel free to call Pre-Registration at (360) 956-2583 or Main Admitting at (360) 754-5858 ext 2801 or 2806.

Date of Procedure: ___/___/___ Procedure: _____ Ordering DR: _____

Patient Legal Name: _____
Last Name First Name Middle

Date of Birth: ___/___/___ Sex: M / F Social Security Number: _____

Mother's first name (for security purposes): _____ Marital Status: _____

Religious preference (if any): _____

Address: _____
Street / PO Box # City Stat Zip code

Home Phone: _____ Work Phone (if applicable) _____

Primary Emergency Contact: _____
Last Name First Name Middle

Primary Contact Address:

_____
Street / PO Box # City Stat Zip code

Primary Contact Phone: _____ Alternate Phone: _____

Relation to Patient: _____

#2 Contact (at different address than patient): _____
Last Name First Name Middle

#2 Contact Address:

_____
Street / PO Box # City Stat Zip code

#2 Contact Phone: _____ Alternate Phone: _____

Relation to Patient: _____

****Please complete the information on the back of this form.**

Parent or Responsible Party: _____
Last Name First Name Middle

Relationship to Patient: _____ Social Security No:_____ Date of Birth: ___/___/___

Address if different from Patient's:

_____
Street / PO Box # City Stat Zip code

Employer Name: _____

Employer Address: _____

Employer Phone:_____ Occupation: _____

_____

Name of Insurance: _____

Insurance Address: _____

Phone Number: _____

Policy/Subscriber/Medicaid Client ID#:_____

Group#: _____

Subscriber Legal Name: _____Subscriber Date of Birth: ___/___/___

Secondary Insurance:

Name of Insurance: _____

Insurance Address: _____

Phone Number: _____

Policy/Subscriber/Medicaid Client ID#:_____

Group#: _____

Subscriber Legal Name: _____Subscriber Date of Birth: ___/___/___

Date your symptoms began: ___/___/___

Date of your last menstrual period: ___/___/___ Estimated Due Date: ___/___/___

Primary Care Physician: _____

OB physician: _____