

PRE-ADMISSION FORM

Please complete the following and deliver/mail/fax to the hospital admitting office prior to your admission date. If you have any questions please call our office and we will be happy to assist you.

**COOKEVILLE REGIONAL MEDICAL CENTER
PATIENT REGISTRATION**

1 Medical Center Boulevard • Cookeville, TN 38501
Telephone: 931-783-2630 • Fax 931-783-2266

PATIENT INFORMATION

Patient Name: _____
FIRST MIDDLE MAIDEN NAME

Patient Address: _____
STREET CITY ST ZIP

Home Phone: () _____ Cell Phone: () _____

Social Security #: _____/_____/_____ Date of Birth: _____ Age: _____

Sex: Female Male Race: _____ Marital Status: _____ Religion: _____

Are you Allergic to any medicines? Yes No If yes, please list: _____

Do you have a Living Will? Yes No Do you have a Power of Attorney? Yes No

Do you want anyone to know that you are a patient here? Yes No

Patient Employer: _____ Work Phone: _____

Address: _____

Spouse's Name: _____ Social Security #: _____/_____/_____

Spouse's Employer: _____ Date of Birth: _____

Employer's Address: _____ Phone: () _____

EMERGENCY CONTACT

Notify in case of an emergency: _____

Address: _____

Relationship: _____ Home Phone: () _____

Cell Phone: _____ Work Phone: () _____

PERSON RESPONSIBLE FOR BILL (if other than patient)

Person Responsible after Insurance: _____ Relationship: _____

Address: _____ Home Phone: () _____

Social Security #: _____/_____/_____ Date of Birth: _____

Responsible Person's Employer: _____ Work Phone: () _____

ADMISSION INFORMATION

Date of Expected Admission: _____/_____/_____ Admitting Physician: _____

Primary Care Physician: _____

Maternity Patients Only: Last Menstrual Period _____/_____/_____

INSURANCE INFORMATION (Complete or attach insurance card copies)

Primary Insurance: _____ Policy #: _____

Insured Name: _____ Group #: _____

Social Security #: _____/_____/_____ Date of Birth: _____

Secondary Insurance: _____ Policy #: _____

Insured Name: _____ Group #: _____

Social Security #: _____/_____/_____ Date of Birth: _____

Signature: _____ Date: _____