

Admissions Pre-Registration Form

Please complete the pre-registration form and fax it to **(512) 380-7561**. This process will decrease registration time when you come to the hospital.

Patient Information:

DATE OF ADMISSION: ____/____/____ DRIVER'S LICENSE NUMBER: _____

LAST NAME: _____ FIRST: _____ MIDDLE: _____

MAIDEN NAME: _____ SEX: ___ FEMALE ___ MALE BIRTHDATE ____/____/____ AGE: ____

HOME ADDRESS: _____ : APT: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

RELIGION: _____ ETHNIC ORIGIN/RACE: _____

YOUR DOCTOR'S NAME: _____

HAS PATIENT EVER RECEIVED CARE AT SETON MEDICAL CENTER AUSTIN: ___ YES ___ NO

IF YOU ATTENDED A CLINIC, WHICH ONE: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ WORK PHONE: _____ EXT. _____

IF AN ACCIDENT, DATE AND TIME OF ACCIDENT: _____

IN CASE OF EMERGENCY:

#1 NAME: _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS: _____ CITY: _____ STATE: _____

HOME PHONE: _____ WORK PHONE: _____

#2 NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____

HOME PHONE: _____ WORK PHONE: _____ EXT. _____

PERSON RESPONSIBLE FOR HOSPITAL BILL:

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

OCCUPATION: _____ EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____ WORK PHONE: _____

METHOD OF PAYMENT:

INSURED'S NAME: _____ INSURANCE CO. NAME #1 _____

GROUP WITH (EMPLOYER'S NAME): _____ POLICY NUMBER: _____

CO. ADDRESS: _____ PHONE NUMBER: _____

INSURED'S NAME: _____ INSURANCE CO. NAME #2 _____

GROUP WITH (EMPLOYER'S NAME): _____ POLICY NUMBER: _____

CO. ADDRESS: _____ PHONE NUMBER: _____