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: _____
LAST 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: _____