

4011 S. Monroe Medical Park Blvd.  
Bloomington, IN 47403  
(812) 825-1111



# Fax

To:	Monroe Hospital	From:	
Fax:	(812) 825-0760	Pages:	2
Phone:		Date:	
Re:	<b>Patient Pre-Registration</b>	cc:	

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-



**PATIENT PRE-REGISTRATION FORM**

**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Other Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Sex: \_\_\_\_\_ Do you smoke? \_\_\_\_\_  
Marital Status:  Married  Single  Widowed  Divorced Do you have:  Advanced Directive  Living Will  
Employer Name: \_\_\_\_\_ Name of Primary Care Physician: \_\_\_\_\_  
Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Physician/Provider who ordered this test or procedure: \_\_\_\_\_

**Emergency Contact Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Relationship to Patient:  Parent  Spouse  Other

\*Complete the section below if you have more than one emergency contact

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Relationship to Patient:  Parent  Spouse  Other

**Reason for Visit:**

For which test/ procedure are you scheduled? \_\_\_\_\_ Was this visit ordered due to an accident? \_\_\_\_\_

**Insurance Information:**

\*\*If you do not have health insurance, and would like to speak to a Financial Counselor regarding payment options, please call (812) 825-0894.

Do you have:  Traditional Medicare  Medicare Replacement Plan Do you have Medicaid?  Yes  No  
Name of Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured's Date of Birth: : \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Group/Account #: \_\_\_\_\_