❑ Kishwaukee Hospital ❑ Valley West Hospital

Physician: ______________________________
Date of Service(s): ______________________
(or due date)
Type of Service: _________________________
Pre Cert / Authorization #: _______________

## PRE-REGISTRATION QUESTIONNAIRE

*This form must be completed and returned to appropriate facility to avoid possible cancellation or delay of your service(s)*

## PATIENT INFORMATION – please print

Name ______________________________ Birth Date ____________ Age _____ Sex: ☐ M ☐ F
Address ______________________________ City / State / Zip ______________________
Phone ____________ Cell ____________ Social Security No. ______________________
Employer's Name ______________________ Phone ______________________
Address ______________________________ City / State / Zip ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Maiden Name ______________
Have you been a patient here before? ☐Yes ☐ No Referring Physician ______________

## GUARANTOR'S INFORMATION: SPOUSE OR LEGAL GUARDIAN

Name ______________________________ Birth Date __________ Relationship ____________
Address ______________________________ City / State / Zip ______________________
Phone ____________ Cell ____________ Social Security No. ______________________
Employer's Name ______________________ Phone ______________________
Address ______________________________ City / State / Zip ______________________

## NOTIFY IN CASE OF EMERGENCY (Someone not in the same household)

Name ______________________________ Phone ____________ Work ____________
Address ______________________________ City / State / Zip ______________________

## INSURANCE INFORMATION

| INSURANCE #1 (Primary) | INSURANCE #2 (Secondary) |
|---|---|
| Insurance Name ______________ | Insurance Name ______________ |
| Address ______________ | Address ______________ |
| City / State / Zip ______________ | City / State / Zip ______________ |
| Insurance Phone No. ______________ | Insurance Phone No. ______________ |
| Group No. ______________ | Group No. ______________ |
| Policy No. ______________ | Policy No. ______________ |
| Policyholder Name ______________ | Policyholder Name ______________ |
| Relationship ______________ | Relationship ______________ |
| Social Security No. ______________ | Social Security No. ______________ |
| ***Please forward a copy of your insurance card for this visit*** | ***Please forward a copy of your insurance card for this visit*** |

I hereby authorize KishHealth System to release to my insurance companies, employer insurance groups, health plans, Medicaid / Medicare programs, its insurance carriers or intermediaries, and authorized external review agencies, any medical records or other information concerning this treatment including this pre-registration record, to process insurance claims and conduct utilization review procedures.

_____________________________________________________________
Signature of patient or guardian Date

_____________________________________________________________
Relationship Witness