ST. JOSEPH'S HEALTH CENTRE | TORONTO

MATERNITY PRE-ADMISSION FORM

PLEASE COMPLETE THIS FORM AND RETURN IT AS SOON AS POSSIBLE
BY COMPLETING THIS FORM, YOU WILL REDUCE WAITING TIME UPON ADMISSION.

INSURANCE INFORMATION – RESPONSIBILITY FOR PAYMENT (PLEASE CHECK)

□ Ontario Health Card □ Other Provincial Insurance □Interim Federal Health □ Uninsured Resident □Non-Resident

NAME ON HEALTH CARD _____

Ontario Health Card Number_____-_____-_____Version Code _____

Is there an expiry date? □ Yes □ No If yes, please state _____/_____/_____
Day Month Year

INTERIM FEDERAL HEATLH #_____Expiry Date _____/_____/_____
Day Month Year

Other Provincial Insurance #_____ Province _____

Have you previously been treated at St. Joseph's Health Centre: Yes □ No □

If yes, what year: _____ Please provide J# from hospital blue card: _____

If previously a patient under a different name please state name: _____

Non-Residents or Uninsured Residents, please contact St. Joseph's Uninsured Patient Liaison at 416-530-6245 to make financial arrangements.

PATIENTS PERSONAL INFORMATION (PLEASE PRINT)

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Patient's mother's first name: _____
Day Month Year

Marital Status: _____ Maiden Name: _____Religion: _____

Language: English □ Yes □No If no, please state language: _____

PATIENT'S PERMANENT HOME ADDRESS

Street: _____ Apartment/Unit#:_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work: _____

Email: _____ Cell: _____

Please complete other side

PERSONS TO NOTIFY IN CASE OF EMERGENCY:

PERSON #1

Name: _____ Relationship to patient: _____

Address: _____ Apt/Unit #: _____ Postal Code: _____

Phone #: _____ City: _____Province: _____

Work#: _____ Cell #: _____

PERSON #2

Name: _____ Relationship to patient: _____

Address: _____ Apt/Unit #: _____ Postal Code: _____

Phone #: _____ City: _____Province: _____

Work#: _____ Cell #: _____

PLEASE INDICATE YOUR FAMILY DOCTORS FIRST AND LAST NAME AND OFFICE PHONE NUMBER AS WELL AS YOUR OBSTETRICIAN OR WIDWIFES FULL NAME.

Family Doctor: _____ Office #: _____

Obstetrician/Midwife: _____

EXPECTED DATE OF DELIVERY: _____/_____/_____
Day Month Year

EXTENDED HEALTH INSURANCE (Your semi or private insurance information)

Insurance Company Name: _____

Policy #: _____ Certificate #: _____ Division: _____

Employee #: _____ Policy Holders I.D. #: _____

Policy Holders Name: _____
Last First

Relationship of Patient to Policy Holder: _____ Employer's Name: _____

Above Employer's Address: _____

City: _____ Province: _____ Postal Code: _____ Phone: _____

PREFFERED ACCOMODATIONS IF AVAILABLE (Please check the appropriate section)

To enhance your comfort, every effort will be made to meet your room preference. Occasionally we will not be able to provide your requested room preference. Private rooms will only be assigned ***after delivery, if available****. We thank you for your cooperation and understanding in this matter.*

Standard Ward (4 Patient's per room) □ Semi-Private (2 Patient's per room) □ Private (1 Patient) □

PLEASE NOTE: YOU MUST BRING YOUR HEALTH CARD TO EVERY HOSPITAL VISIT.

YOUR HEALTH CARD AND OTHER INSURANCE CARDS MUST BE SHOWN AT TIME OF ADMISSION. IF YOU DO HAVE EXTENDED HEALTH INSURANCE PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO ADMISSION, TO BE CERTAIN OF THE COVERAGE OFFERED BY YOUR PLAN.

DATE: _____ *SIGNATURE*: _____