

# Culpeper Regional Hospital Pre-Admit Form

This form, when completed, contains information to begin your medical record and to bill your insurance. For medical and surgical procedures, please send it at least 15 days before your scheduled arrival date. Obstetrical patients, please send it in as soon as possible after the end of your fifth month of pregnancy. You may call (540) 829-4192 if you have any questions. Please complete the form and *fax* it to (540) 829-5749, or mail it to: **Culpeper Regional Hospital Admitting Department - P.O. Box 592, Culpeper, VA 22701**

## PATIENT INFORMATION

Last Name	First Name	Middle Initial	Birthdate	Age	Sex	Mothers Maiden Name
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Address	City	State	Zip Code	Home Phone
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Social Security Number	Marital Status	Race/Ethnicity	Religion/Faith	Parish/Church
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Occupation	Employer	Employer Address	City	State	Zip Code
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Business Phone	Length of Employment	Birthplace	Drivers License Number
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<i>Spouse or nearest Relative</i>	<i>Birthdate</i>	<i>Relation to Patient</i>	<i>Social Security Number</i>
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<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Home Phone</i>
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<i>Occupation</i>	<i>Employer</i>	<i>Employer Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Business Phone</i>
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## INSURANCE INFORMATION

Primary Insurance Company	Subscriber	Policy Number	Group Number
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Primary Insurance Address	City	State	Zip Code	Phone
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Secondary Insurance Company	Subscriber	Policy Number	Group Number
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Secondary Insurance Address	City	State	Zip Code	Phone
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## MEDICAL INFORMATION

Attending Physician	Phone	Address	City	State	Zip Code
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Type of Upcoming Service:	Inpatient	Outpatient	Obstetrical
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Prior Patient at Culpeper Regional Hospital?	Yes	No	Please list any other name(s) for prior admits _____
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Please confirm my Pre-Admit registration by:    Email \_\_\_\_\_    Phone \_\_\_\_\_    Fax \_\_\_\_\_    Rev: 9-4-01