OSC orthopedic SURGERY CENTER

# PRE-ADMISSION FORM

Please provide this information to the admissions department as soon as you receive this packet. Be sure to include a daytime phone number. You may FAX this form to 225-763-6163 or call the admissions department at 225-763-6011.

## PATIENT INFORMATION

| Date of Surgery | Surgeon/Physician | Referring Physician |
|---|---|---|
| Patient's Legal Name (first, MI, last) | Nickname | If Minor, Provide Parent's Name |

| SS # | Birth Date Month Day Year | Age | ☐M ☐F |
|---|---|---|---|

Patient's Mailing Address:

Street & Apt. _____

City _____ State _____

Zip _____ Home Phone ( ) _____ Work Phone ( ) _____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed ☐Separated Cell Phone ( ) _____

Name of nearest friend or relative not living with you _____ Phone _____ Relationship _____

## INSURANCE INFORMATION

| Medicare No. | Medicaid No. | |
|---|---|---|
| Name of Primary Insurance: ☐PPO ☐HMO | Group No. | Policy No. |

Insurance Address:

Street or Box _____

City _____ State _____

Zip _____ Phone ( ) _____

Policy Holder's Date of Birth ____/____/____

Injury or Accident? ☐Yes ☐No

If yes, date _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's Name _____ SS # _____

Street or Box _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Office Phone _____

| Name of Secondary Insurance: ☐PPO ☐HMO | Group No. | Policy No. |
|---|---|---|

Insurance Address:

Street or Box _____

Policy Holder's Date of Birth ____/____/____

City _____ State _____

Zip _____ Phone ( ) _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's Name _____ SS # _____

Street or Box _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Office Phone _____

## WORKER'S COMPENSATION INFORMATION

| Worker's Comp. Company Name | Adjustor or Contact name | Date of Injury |
|---|---|---|

Street or Box _____

City _____ State _____

Zip _____ Phone ( ) _____