Pre-Admission Registration Form

Boise ☐ Jerome ☐ McCall ☐ Meridian ☐ Twin Falls ☐ Wood River ☐

Please fill out completely, fold twice and seal, making sure St. Luke's address is on the outside. No postage required.
Please bring your insurance card and Photo ID when you come to the hospital.

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE, LAST): PREVIOUS LAST NAME(S):	SSN:	SEX: M ☐ F ☐	DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
LANGUAGE:	MARITAL STATUS:	EMAIL ADDRESS:	
RELIGION:	WOULD YOU LIKE YOUR RELIGIOUS INFORMATION TO BE MADE AVAILABLE TO THE CHAPLAIN? Y ☐ N ☐		
ETHNICITY:	RACE:	BIRTH STATE:	

EMPLOYMENT INFORMATION

EMPLOYER:	EMPLOYMENT STATUS:	OCCUPATION:	
ADDRESS:	CITY:	STATE:	ZIP:

PRIMARY CONTACT INFORMATION

NAME & RELATIONSHIP TO PATIENT:	PRIMARY PHONE:	OTHER PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:

SECONDARY CONTACT INFORMATION

NAME & RELATIONSHIP TO PATIENT:	PRIMARY PHONE:	OTHER PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:

GUARANTOR INFORMATION – Person Responsible for Bill

NAME & RELATIONSHIP TO PATIENT:	SSN:		DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
EMPLOYER:	EMPLOYMENT STATUS:	OCCUPATION:	

COVERAGE INFORMATION: PRIMARY

Maternity visits only - This insurance plan is for : ☐Mom only ☐Baby only ☐ Mom and baby

INSURANCE PLAN NAME:	SUBSCRIBER NAME:	SUBSCRIBER DATE OF BIRTH:
PATIENT'S RELATIONSHIP TO SUBSCRIBER:	POLICY/ID NUMBER:	EFFECTIVE FROM:
SUBSCRIBER ADDRESS & PHONE#:	GROUP NUMBER:	GROUP NAME:
INSURANCE ADDRESS:	INSURANCE PHONE NUMBER:	NETWORK (Circle One): PPO, IPN, Bright Path, First Health, CCN
COVERED THROUGH: ☐CURRENT EMPLOYER ☐RETIREMENT ☐OTHER		EMPLOYER SIZE:

COVERAGE INFORMATION: SECONDARY

Maternity visits only - This insurance plan is for : ☐Mom only ☐Baby only ☐ Mom and baby

INSURANCE PLAN NAME:	SUBSCRIBER NAME:	SUBSCRIBER DATE OF BIRTH:
PATIENT'S RELATIONSHIP TO SUBSCRIBER:	POLICY/ID NUMBER:	EFFECTIVE FROM:
SUBSCRIBER ADDRESS & PHONE#:	GROUP NUMBER:	GROUP NAME:
INSURANCE ADDRESS:	INSURANCE PHONE NUMBER:	NETWORK (Circle One): PPO, IPN, Bright Path, First Health, CCN
COVERED THROUGH: ☐CURRENT EMPLOYER ☐RETIREMENT ☐OTHER		EMPLOYER SIZE:

PRIMARY CARE PROVIDER

NAME:	PHONE:		
ADDRESS:	CITY:	STATE:	ZIP:

ADDITIONAL INFORMATION

PHYSICIAN:	Surgical: ☐ Maternity: ☐	Admit date or if maternity, due date:
IS THIS ADMISSION RELATED TO AN ACCIDENT: YES ☐ NO ☐	IF ACCIDENT RELATED, LIST ACCIDENT DATE, TIME & ACCIDENT DETAILS:	IF ACCIDENT RELATED, LIST ACCIDENT LOCATION: HOME ☐ WORK ☐ AUTO ☐ OTHER ☐