North Shore LIJ Huntington Hospital
North Shore-Long Island Jewish Health System

HUNTINGTON HOSPITAL – PRE REGISTRATION/ADMISSION FORM

□ Ambulatory (one-day-surgery) □ In Patient Surgery □ Maternity Admission

DATE OF EXPECTED REGISTRATION/ADMISSION__________ _/_________ _/_____ _ ___ DOCTOR ____

NAME: ____ DATE OF BIRTH______/______/______PREFERREDCONTACT NUMBER______-_______-______

ADDRESS____CITY__________________________________STATE __________ ZIP CODE__________________

EMERGENCY CONTACT___________________________________RELATIONSHIP_______________________ CONTACT PHONE NUMBER_______-_____-_______

ADDRESS____ CITY_____________________________________STATE_____________ZIP CODE_______________

NEAREST RELATIVE_____________________________________RELATIONSHIP________________________CONTACT PHONE NUMBER_______/_______/______

ADDRESS____ CITY______________________________________STATE______________ZIP CODE______________

PRIMARY INSURANCE COVERAGE- CARD HOLDER INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT____

RELATIONSHIP TO PATIENT____ SOCIAL SECURITY #___________-_________-______________

ADDRESS IF DIFFIRENT FROM PATIENT____________________________________CITY_________________________________STATE________ZIP CODE________

PERSON RESPONSIBLE EMPLOYED BY____

OCCUPATION____BUSINESS PHONE___________-__________-____________

BUSINESS ADDRESS____ CITY________________________________STATE___________ZIP CODE___________

INSURANCE CARIRIER____

ID#____GROUP#____

SECONDAY INSURANCE COVERAGE – CARD HOLDER INFORMATION

Card Holder____

RELATIONSHIP TO PATIENT____ SOCIAL SECURITY #_________-_________-_________________________

ADDRESS IF DIFFIRENT FROM PATIENT_______________________________________CITY_____________________________STATE________ZIP CODE_________

CARD HOLDER EMPLOYED BY______________________________________OCCUPATION_____________________BUSINESS PHONE________-________-________

BUSINESS ADDRESS____CITY_____________________________STATE___________ZIP CODE___________

INSURANCE CARIRIER____ID#___________________________________GROUP#_________________________________

MATERNITY PATIENTS ONLY: Date of Last Menstrual Period________/_______/_________

Patient's Maiden Name____

Name of Newborn's Father____ Date of Birth______/_____/_____