El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

815 Pollard Road, Los Gatos, CA 95032

Please complete and return form to Patient Registration prior to the date you are to enter the hospital

PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARDS OR BRING THEM WITH YOU ON ADMISSION

Patient Registration Department: Los Gatos 408-866-4062

PRE-ADMISSION RECORD

PATIENT INFORMATION

Date To Enter Hospital	Physician	Maternity ☐ Yes ☐ No	Primary Care Physician (PCP)	Due Date / /	Maiden Name: Previous Name:	Approximate Date Last Treated	I authorize the hospital to verify my insurance benefits for this hospital service. ☐ Yes ☐ No Signature

Patient's Legal Name (Last, First, Middle)	Place of Birth	Date of Birth	Age	Sex	Marital Status	Religious Preference	Social Security Number

Patient's Address (Street, City, State, Zip Code)	Email Address	Patient's Home Phone

Patient's Employer	Occupation	Patient's Work Address (Street, City, State, Zip Code)	Patient's Work Phone

Name of Emergency Contact	Address (Street, City, State, Zip Code)	Home Phone	Work Phone	Relationship to Patient

Name of Person Responsible for Hospital Bill (if other than patient)	Address (Street, City, State, Zip Code)	Home Phone	Relationship to Patient

Ethnicity ☐ Hispanic ☐ None-Hispanic	Principal Language Spoken:	Race *The State requires hospital to collect statistical information on* Race and Ethnicity. *Providing this information is voluntary.* ☐ White ☐ Black ☐ Asian / Pacific Islander ☐ Native American / Eskimo ☐ Other

INSURANCE COVERAGE INFORMATION

EMP STATUS: ☐ FT ☐ PT ☐ DISABLED ☐ RETIRED

PRIMARY INSURANCE

Insurance Company Name	Identification Number	Group Number	Insured Person's Name	Insured's Sex	Insured's Employer	Work Phone

Insured's Birthdate	Insured's Social Security Number	Patient's Relationship to Insured	Authorization Number	Insurance Verification Phone Number

SECONDARY OR SUPPLEMENTAL INSURANCE

Insurance Company Name	Identification Number	Group Number	Insured's Person Name	Insured's Sex	Insured's Employer	Work Phone

Insured's Birthdate	Insured's Social Security Number	Patient's Relationship to Insured	Authorization Number	Insurance Verification Phone Number

WORK RELATED INJURY

Employer at Time of Injury	Employer's Address (Street, City, State, Zip Code)	Employer's Work Phone	Date of Injury

Industrial Insurance Name	Industrial Insurance Address (Street, City, State, Zip Code)	Ind Insur Phone Number	Claim Number (if known)

CHAMPUS

Patient is a: ☐ Spouse ☐ Child ☐ Retiree	Card Number	Effective Date	Expiration Date	Name of Sponsor (Last, First, Middle)	Service Number	Grade

Social Security Number	Organization & Duty Station (Home Port/Retiree's Address)	Branch of Service ☐ USA ☐ USAF ☐ USMC ☐ USN ☐ USCG ☐ USPHS ☐ EESA	Status: ☐ Active Duty ☐ Retired ☐ Deceased