The Women's Hospital Patient Registration Form

To ensure that your registration goes as smoothly as possible, please fill out this form completely and return it in the postage-paid envelope provided. Or you may leave it with the receptionist at the information desk in the main lobby. Please have your insurance cards and a driver's license or picture ID with you whenever you come to the hospital. **If you have any questions about the registration process, please call 812-842-4241.**

Patient Last Name **First Name** **MI**

Street Address

City **State** **ZIP**

Patient Home Phone **Patient Work Phone**

Social Security # **Date of Birth**

Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Patient Employer

Employer Address, City, State, ZIP

I work: ☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Unemployed**

Surgery Date or Maternity Due Date

Admitting Dr.'s Name Family Dr.'s Name

Name of church you wish to be notified

Do you have a living will? ☐ Yes ☐ No Power of Attorney? ☐ Yes ☐ No

INFO FOR PERSON FINANCIALLY RESPONSIBLE FOR HOSPITAL BILL

Who Carries the Insurance? ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Responsible Person's Last Name First Name MI

Address, City, State, ZIP

Phone Social Security # Date of Birth

Responsible Person's Employer

Employer Address and Phone

INSURANCE INFORMATION

Patients without medical insurance coverage will be asked to prepay an estimated bill. Before being discharged, insured patients will be expected to pay any co-insurance, deductibles and/or other charges that insurance does not pay. Payment can be made by cash, check or major credit card. **If you have questions, contact our financial counselors at 812-842-4240.**

NAME OF PRIMARY INSURANCE

☐ Male ☐ Female

Name of Policy Holder

Policy Holder's Social Security # Policy Holder's Date of Birth

Policy Number Group Number Effective Date

Insurance Phone #

Name of Employer Who Provides This Insurance

NAME OF SECONDARY INSURANCE (If Applicable)

☐ Male ☐ Female

Name of Policy Holder of Secondary Insurance

Policy Holder's Social Security # Policy Holder's Date of Birth

Policy Number Group Number Effective Date

Insurance Phone #

Name of Employer Who Provides This Insurance

PLEASE COMPLETE THE FOLLOWING IF YOU ARE PREGNANT

INSURANCE BABY WILL BE COVERED BY

☐ Male ☐ Female

Name of Policy Holder

Policy Holder's Social Security # Policy Holder's Date of Birth

Policy Number Group Number Effective Date

Name of Employer Who Provides This Insurance

Employer Address, City, State, ZIP

1st Emergency Contact Relationship Address Phone

2nd Emergency Contact Relationship Address Phone

TEAR HERE