Huntington Hospital

Pre-Registration Form

Will this visit be: ❑Inpatient ❑Outpatient ❑Not Sure (check one)
Arrival Date: _____
Procedure or Type of Test: _____

Have you ever been a patient at Huntington Hospital? ❑Yes ❑No (check one)
If yes, date of most recent visit: _____

Patient Information

Patient Name: _____ **Date of Birth**:_____
First Name Middle Initial Last Name
SSN: _____ **Sex**:_**M / F**___ **Primary Language**:_____
Circle One
Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:_____ **Alternate Phone No**:_____ **Best time(s) to reach you**: _____

Marital Status: _____ **Race**: _____ **Ethnicity**: _____ **Place of Birth**: _____ **Religion**: _____

Reason for Visit (Diagnosis): _____
Is this visit related to a work/auto/other type of injury? ❑Yes ❑No **How**: _____

Primary Care Drs Name (if applicable**)**: _____ Phone: _____ Address**:** _____

Employer: _____ Occupation: _____

Phone: _____Address:_____ City: _____ St:_____ Zip Code: _____

Contact Information

Next of Kin: _____ **Relationship**: _____

Home Phone: _____ **Work/Cell Phone**:_____

Person to Notify: _____ **Relationship**: _____

Home Phone: _____ **Work/Cell Phone**:_____

Guarantor: _____ SSN: _____**Relationship**: _____
First name Middle Initial Last Name
(Guarantor is required if patient is a minor)
Address: _____ City: _____ St:_____ Zip Code: _____

Home Phone:_____ **Work Phone**:_____ Occupation:_____

Guarantor Employer: _____ Address: _____City: _____ St:___ Zip Code: _____

Insurance Information

Primary Insurance: _____ **Subscriber Name**: _____ **Rel to Pt**: _____ **Date of Birth**:_____ **SSN**: _____

Policy #:_____Group Name: _____ **Group #**: _____ **Ins Co Phone**:_____

2nd Insurance: _____ **Subscriber Name**: _____ **Rel to Pt**: _____ **Date of Birth**:_____ **SSN**: _____

Policy #:_____Group Name: _____ **Group #**: _____ **Ins Co Phone No** _____

Advance Directive Information

Advance Directive for Health Care: ❑Yes ❑No **Living Will**: ❑Yes ❑No **Power of Attorney:** ❑Yes ❑No

Who is proxy Agent: _____ Relationship: _____Phone: _____

For Pre-Registration questions contact the Call Center Phone No at (626) 397 5600
Fax or Mail in completed Pre-Registration form with a copy of insurance card(s) to:
Huntington Memorial Hospital Attn: Call Center 100 W California Bl Pasadena CA 91109-7013
-or- Fax No (626) 397 2160