fraserhealth

Preregistration Form

SITE: .... Last Visit ________

Previous Visits ❑ RCH ❑ ERH ❑ RMH ❑ BBY ❑ OTHER ________ Date ________

Maternity Patient Pregnancy 1, 2, 3? Due Date: Allergy ❑ Y ❑ N

LEGAL NAME

________ | ________ | ________

Last *(Smith)* First *(James)* Middle *(William)*

Other Name Used ________ Previous / Maiden ________

Example *Smith, Jim*

Date of Birth ________ *(Day/Month/Year)* Religion ________

Sex ❑ Male ❑ Female ❑ Married ❑ Single ❑ Divorced ❑ C.Law

Current Address ________

STREET *CITY* *PROVINCE* *POSTAL CODE*

Home Phone # ________ Work Phone # ________

Length of Residence at present address ________ Month ________ Year ________

CARE CARD

PHN or Other Province Number ________

Province ________

Are you an Organ Donor? ❑ Yes ❑ No

Employer Name ________

Address ________

Occupation ________ Telephone ________

Guarantor *Person who is primary applicant for Medical Plan*

(If self, enter "self") Name ________

Employer ________ Telephone ________

Next of Kin *(Spouse, common-law, mother, father brother, sister, etc.)*

Name ________

Address ________

Telephone ________ Relationship ________

INJURY DETAILS

If your admission is due to an injury, please complete the details below

Date of Injury ________ Time ________ Where ________

Type of Accident ________

WCB ❑ Claim #________

Physicians Family Doctor ________

Specialist(s) ________

Accommodation Requested ❑ Private ❑ Semi-Pr ❑ Ward

Extended Benefits

Company ________ Address ________

Claim# ________

If you have Extended Benefits and request a Private or Semi-Private Room please complete the attached Claim Form and Sign.

B.C. Resident ❑ Y ❑ N If NO - Date of arrival

Previous Address ________

If less than six months at current address ________

Please read back of Form for Instructions

Maternity Patient

If you are a maternity patient please record which pregnancy this is in the appropriate box and give your approximate due date.

Legal Name

Your legal name is your LAST, FIRST, and MIDDLE name if applicable.

Other Name Used (nick names)

If you go by another name then we need to know this to cross-reference to give information to callers while your are in the hospital.

Previous / Maiden Name

Your previous name through marriage and your maiden name.

Care Card Number

Enter the number from your Care Card and then your residing Province. If you are from another Province, please ask for an Out of Province Claim Form when you are being admitted to hospital. This guarantees that all Forms are sent in on a timely basis.

Employer

This is the patient's employer, employer's address and patient's occupation.

Guarantor

If the Medical Insurance is not held by the patient then the Guarantor is the person who is the primary holder of the Medical insurance.

Injury Details

We need a short description of your injury - Where, When, How? If this is a WBC related injury please record the Claim Number.

Private and Semi-Private Room Request

If you wish to have a preferred accommodation either Private or Semi-private record it and we will do everything possible to accommodate you. If you have Extended Health Insurance which covers a portion of your accommodation request please record the Health Insurance Company Name Address and Claim Number.

B.C. Resident

In order to be eligible for the hospital per diem rate you must be a B.C. Resident. Enter the date of arrival in B.C. or if you were born in B.C. enter "Born". If you have any questions regarding this form please call the following numbers for additional information:

RCH	520-4214 / 520-4218
ERH	461-2022
RMH	463-4111