



(ESTIMATED) DUE DATE: _____

PRE-ADMISSION REGISTRATION

1. COMPLETE AND RETURN TO HOSPITAL MAIN LOBBY RECEPTION DESK BY YOUR 27TH WEEK OF PREGNANCY.
2. BRING INSURANCE CARDS AND/OR POLICIES WITH YOU AT TIME OF ADMISSION.

INFORMATION WE NEED TO KNOW ABOUT YOU, THE PATIENT

NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____ DATE OF BIRTH: _____
 ADDRESS: (mailing) _____ PHONE: _____
 ADDRESS: (location if different from mailing) _____
 CITY, STATE & ZIP: _____
 SOCIAL SECURITY NUMBER: _____ SEX: _____ MARITAL STATUS: _____
 LOCAL CHURCH OR RELIGION: _____ AGE: _____ SMOKER: _____
 IF STUDENT, WHERE: _____ PHYSICIAN: _____
 HAVE YOU BEEN A PATIENT HERE BEFORE? _____ ARE YOU A HASTINGS OR FHPCC PATIENT? _____
 PLACE OF EMPLOYMENT: _____ PHONE: _____
 ADDRESS: _____ OCCUPATION: _____
 CITY, STATE & ZIP: _____
 NOTIFY IN EMERGENCY: _____ PHONE: _____
 ADDRESS: _____ RELATIONSHIP: _____
 CITY, STATE & ZIP: _____

INFORMATION WE NEED TO KNOW ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT FROM PATIENT)

NAME: _____ RELATIONSHIP TO PT: _____
 ADDRESS: _____ PHONE: _____
 CITY, STATE & ZIP: _____
 SOCIAL SECURITY NUMBER: _____ OCCUPATION: _____
 PLACE OF EMPLOYMENT: _____ PHONE: _____
 ADDRESS OF EMPLOYER: _____
 CITY, STATE & ZIP: _____

INFORMATION WE NEED TO KNOW ABOUT YOUR MEDICAL INSURANCE (COMPLETE ALL THAT MAY APPLY TO YOU)

MEDICARE NO: _____ MEDICAID NO: _____ GROUP #: _____
 WHOSE NAME IS ON POLICY OR CARD? _____
 INSURANCE COMPANY: _____ POLICY NO: _____
 ADDRESS OF INSURANCE COMPANY: _____
 CITY, STATE & ZIP: _____ PHONE #: _____
 GROUP? () INDIVIDUAL? () IF GROUP, WITH WHOM? _____

IF YOU HAVE NO MEDICAL INSURANCE, IT IS NECESSARY THAT YOU CONTACT THE BUSINESS OFFICE PRIOR TO ADMISSION IN ORDER TO MAKE CERTAIN FINANCIAL ARRANGEMENTS. PHONE 819-4539.

THANK YOU FOR CHOOSING FLAGLER HOSPITAL.



CONSENT AND CONDITIONS OF TREATMENT

CONSENT FOR TREATMENT:

The undersigned requests and voluntarily consents to the patient's receipt of the usual hospital services, as well as the diagnostic procedures, laboratory tests and x-ray procedures (including intravenous injection of contrast material) and medical and surgical treatment judged to be necessary by the patient's attending physician, his assistants, or other practitioners consulted or designated by him.

In consideration of the care and treatment to be rendered to the patient by Flagler Hospital, I agree and consent to the following conditions:

- 1. MEDICAL CARE: The undersigned acknowledges that the physicians on the medical staff of Flagler Hospital are not employees or agents of the hospital, but are independent practitioners who have been granted the privilege of using hospital facilities for the care and treatment of their patients. The undersigned understands that no guarantees have been made as to the results of the treatments or examinations in the hospital.
2. PERSONAL VALUABLES: For the convenience of the patient, a vault for safekeeping of patient's valuables is available without charge in Patient Services. Flagler Hospital will not be liable for the loss or damage to any personal property of the patient brought to the hospital except that which is properly deposited in Patient Services.
3. COMPLIANCE WITH RULES AND REGULATIONS: The undersigned agrees that the patient will abide by the rules of Flagler Hospital.
4. RELEASE FROM RESPONSIBILITY: The undersigned agrees that Flagler Hospital is not responsible for injuries sustained from the patient's use of the patient's own personal equipment, electrical, mechanical or otherwise. It is further agreed and understood that should the patient leave the hospital without the consent of the patient's attending physician, the undersigned hereby relieves said physician and the hospital of all responsibility for such action.
5. PAYMENT RESPONSIBILITY: The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of Flagler Hospital and physicians treating the patient in the hospital relating to services rendered by the hospital and physicians to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party, which amounts shall be due within ten (10) days of the billing date. Amounts due from the patient to the hospital prior to the execution of this agreement may, at the sole discretion of the hospital, be consolidated with and made a part of the amount hereunder. The patient or guarantor shall pay all costs of collection in connection with the enforcement of this commitment, including reasonable attorney's fees and court costs incurred by the hospital and physicians.
6. ASSIGNMENT OF BENEFITS: The patient hereby makes the assignment of benefits as set forth below:
MEDICARE: The patient hereby requests that payment of authorized Medicare benefits to or on behalf of the patient for services furnished in or by Flagler Hospital shall be made to the hospital and the patient specifically assigns such benefits to the Hospital. The undersigned certifies that all information given by the patient in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects and permits a copy of this authorization to be used in place of the original. The patient understands that payment for certain services such as medication that could be self-administered are not authorized under the Medicare program and that the patient shall be responsible for the entire charge incurred unless other third party coverage is available. The patient also understands that all deductibles are due unless they have been met within the last sixty (60) days.
PHYSICIANS: The patient hereby assigns benefits to all physicians involved in the care of the period of illness or treatment.
OTHER THIRD PARTY PAYERS: The patient hereby assigns to Flagler Hospital and physicians all benefits under any insurance policy, health plan, worker's compensation or other third party payer liable to the patient, in consideration for services rendered by the hospital and physicians.
7. CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION: The undersigned consents to the use and disclosure of protected health information for the purposes of treatment, payment and healthcare operations. The undersigned acknowledges that the patient has been provided with a Notice of Privacy Practices that provides a complete description of information uses and disclosure.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR OTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ THE FOREGOING, UNDERSTAND ITS CONTENT AND ACCEPT ITS TERMS:

Signature of Patient

Date

When patient is unable to sign, I hereby consent for the patient:

Signature

Date

Relationship to Patient

Hospital Witness to Signature



FLAGLER HOSPITAL, INC.
400 Health Park Blvd.
St. Augustine, FL 32086

A NOTICE TO OUR ADULT PATIENTS REGARDING YOUR RIGHT TO ACCEPT OR REFUSE TREATMENT AND RIGHT TO MAKE AN ADVANCE DECLARATION CONCERNING LIFE PROLONGING PROCEDURES, A "LIVING WILL."

THE STATE OF FLORIDA RECOGNIZES YOUR RIGHT TO PRIVACY IN THE CONSTITUTION. UNDER THE STATE CONSTITUTION YOU HAVE THE RIGHT TO GIVE CONSENT OR TO REFUSE ANY MEDICAL OR SURGICAL TREATMENT AT ANY TIME. THE STATE ALSO PROVIDES, UNDER FLORIDA STATUTE 765, THAT YOU MAY MAKE A WRITTEN DECLARATION OF YOUR WISHES CONCERNING THE PROVISION OF LIFE-PROLONGING PROCEDURES SO THAT YOUR WISHES CAN BE FOLLOWED IN THE EVENT THAT YOU HAVE A TERMINAL CONDITION AND ARE UNABLE TO MAKE DECISIONS FOR YOURSELF.

UNDER FLORIDA LAW, YOU ALSO HAVE THE RIGHT TO NAME ANOTHER INDIVIDUAL TO MAKE HEALTH CARE DECISIONS FOR YOU IN THE EVENT THAT YOU BECOME INCAPABLE OF DOING SO.

IF YOU DO NOT HAVE A LIVING WILL OR HAVE NOT NAMED A HEALTH CARE SURROGATE, THE HOSPITAL CAN ASSIST YOU IN DOING SO. TREATMENT IN FLAGLER HOSPITAL IS NOT CONTINGENT ON YOUR HAVING MADE AN ADVANCED DIRECTIVE OR HAVING NAMED A SURROGATE.

CERTIFICATION

I hereby certify that I have been given notice of my rights to consent or refuse treatment, my right to execute an advance directive regarding life-prolonging procedures and my right to name a health care surrogate. I have also been given information on how I can make an Advance Directive if I wish to do so.

SIGNATURE

DATE

I have made a living will _____

I have not made a living will _____

RIGHT TO MAKE AN ADVANCED DECLARATION

OB PRE-ADMISSION INFORMATION

DUE DATE (ESTIMATED) _____

Name: _____ **DOB** ___/___/___ **Doctor/Midwife** _____
Last First

Health history (lung/heart/kidney problems):

Do you follow a special diet at home?
No/ Yes: _____
Any foods you avoid? _____
Any specific food preferences? _____

Pre-Admission Data

Level of education (highest grade completed):

Is there a family history of hearing loss
before the age of 6 y/o? Yes No
Father of baby involved? Yes No
Do you receive WIC? Yes No
... have a car seat? Yes No
... live with spouse/parent/other _____
Primary language? _____
How will you feed baby? Breast / Bottle/ Both
Planning for: Epidural / Spinal / None
Any risk factors for this pregnancy (i.e. preterm
labor, infection, diabetes, bleeding?)

Any previous OB problems?

of Stillbirths? _____ Date of last: ___/___/___
Alcohol use? No /Yes: Amt per week _____
*Drug use? No / Yes: List: _____

Ok to give baby Hepatitis B vaccine? Yes No
History of diabetes? No Yes: Insulin Pump? Yes No
History of any surgeries? What and year?

Previous Cesarean section? No / Yes # _____
Reason: _____
Any uterine surgeries? What and year?

History of any STDs? No / Yes:

History of depression or anxiety? Yes No
Med. Rx? _____

Other mental issues? Yes No
Please list: _____

Is baby up for adoption? Yes No
If yes, do you want infant contact? Yes No

Are you on dialysis? Yes No
Do you have a history of MRSA? Yes No

Would you like an interpreter? Yes No
Do you smoke? No / Yes: # per day? _____

Your religious denomination: _____
Would you like a Chaplin visit? Yes No

Cultural preferences or practices during
hospitalization? No Yes: _____

History of physical abuse? Yes No
Do you feel safe now? Yes No

Any Allergies to medications? Yes No
What? _____

Reaction? _____
Other Allergies (i.e. Food)? _____

Iodine Allergy? Yes No
Latex Allergy? Yes No

Any recent falls? Yes No
Date of last Tetanus vaccine: ___/___/___

Any exposure to communicable diseases?
(i.e. Measles/Mumps/Chicken Pox/ Tuberculosis)
No / Yes: Type/date? _____

Medications you take at home (include vitamins,
antacids, Tylenol* :

Questions/Comments?

*Please write on back if extra space is needed.

