OMEGA Hospital

PATIENT LABEL

Pre-Admission Registration

Omega Scheduling to Complete:

Scheduled Admission Date: _____ Admitting Diagnosis: _____

Dear Patient:
Thank you for choosing Omega Hospital, LLC for your healthcare needs. Please complete the registration below to assist us in accurately completing our records.

Have you had a previous admission to Omega Hospital, LLC? ☐ Yes ☐ No

First Name:		Middle Initial:		Last Name:		
Address:		Apt. #:	City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:		Emergency Phone:	
Patient S.S.#:	Date of Birth:	Marital Status:	Sex:	Race:	Religion:	Birthplace:
Occupation of Patient:		Employer:		Employer's Address (City/State/Zip):		
Email Address:		Job Injury: Y / N	Date of Injury:		How Injured:	
Guarantor (person responsible other than Ins. Co.:		Guarantor Relation to patient:		Guarantor SS#:		
Address:		Apt. #:	City:		State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:		Guarantor's Occupation:	
Guarantor's Employer:			Employer's Address (City/State/Zip):			
Name of Nearest Relative:	Relationship:		Address (Apt. No./City/State/Zip):		Telephone No:	
Emergency Contact:	Relationship:		Address (Apt. No./City/State/Zip):		Telephone No:	

Omega Scheduling to Complete:

Insurance Company:	**Subscriber's Name:**	**Policy No:**	**Group No:**	**Group Name:**

_____ _____ _____

Time **Date** **Omega Hospital, LLC Representative**

Rev. 07/2017