PATIENT LABEL

PRE-ADMISSION REGISTRATION

<u>**Omega Scheduling to Complete:**</u>

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:	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**

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