705502 (1999 - 10)

HAMILTON HEALTH SCIENCES
PRE-ADMISSION REGISTRATION

PLEASE PRINT CLEARLY - and return this form to the Admitting Department, prior to your admission

(Complete both sides of the form)

	Year	Month	Day
Date of Pre-op			
Date of Admission			
Maternity Due Date			

Have you been previously admitted to: ☐ Chedoke Campus ☐ General Campus ☐ Juravinski Campus ☐ McMaster University Medical Centre (MUMC) Campus

Patient Surname | Legal First | Middle

Alternate / Previous / OR Maiden Name | Legal First | **Date of Birth** Year Month Day | **Sex** ☐ Male ☐ Female

Home Address | Apartment or Unit Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law | **Language Preferred** Interpreter Services available in most languages upon request

Religion | **Do you wish a Clergy visit while a patient at the hospital** | **Do you wish to access the services of the Aboriginal Community Health Representative while a patient at the hospital?**

Health Insurance Card Number | Province | **Version Code** (If applicable) Letter(s) in corner of card | **Name as it appears on card**

Out of Country Insurance Company: Name | Address | Phone | **Contract Number**

PERSON TO NOTIFY IN CASE OF EMERGENCY

Surname First | **Relationship to Patient**

Address | Apartment Unit or Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

NEXT OF KIN - Same as above ☐

Surname First | **Relationship to Patient**

Address | Apartment Unit or Number

City | Province | Postal Code | **Home Phone** ( ) | **Business Phone** ( ) Ext:

WORKERS SAFETY INSURANCE BOARD (WSIB) - If a WSIB case, please complete the following information:

Claim Number | **Social Insurance No.** | Employer at Time of Accident | Nature of Injury

Address | City | Province | Postal Code

Place of Accident | Date of Accident Year Month Day | Time of Accident

PHYSICIAN INFORMATION

Surgeon / Specialist Surname | Initials | **Family / Physician:** Surname | Initials

Address | City | Address | City

Province | Postal Code | **Phone** ( ) | Province | Postal Code | **Phone** ( )

Do you have any Medic Alerts?
(Conditions that the hospital should be aware of) ☐ **No** ☐ **Yes** (if Yes, specify) _____

Do you have any Food / Drug / Medication Allergies? ☐ **No** ☐ **Yes** (if Yes, specify) _____

Are you currently taking any medications (including prescribed, over-the-counter or herbal)? Please bring a list, including dosages with you.