Return Form To: Admitting Department
Peterborough Regional Health Centre
1 Hospital Drive
PETERBROUGH, ON K9J 7C6
705-743-2121, Ext. 3103 - Fax – 705-876-5107

PETERBOROUGH REGIONAL HEALTH CENTRE
BIRTHING PRE-ADMISSION FORM

ACCT. #____________________

PLEASE complete & return this form at least 10 weeks before your expected date of delivery. Helps to ensure follow up on discharge.

Expected Date of Delivery: _______ /_______ /_______ (DAY/MONTH/YEAR) **Previous Patient at PRHC:** ☐ Yes ☐ No

Family Dr.____________________ **Attending Dr./Midwife:**____________________

Expected Date of Discharge From Hospital: For Normal Vaginal Births: 24 hrs. **For Caesarean Births:** 48 hrs.

1. LAST NAME	ALL GIVEN NAMES **(no Initials) Underline** Name Used	ANY PREVIOUS LAST NAME AND MAIDEN NAME	
2. HOME ADDRESS (STREET, R.R., BOX, APT.)	CITY/TOWNSHIP	POSTAL CODE	RELIGION
3. HOME TELEPHONE AREA CODE ________ - ________________	DATE OF BIRTH: DAY MONTH YEAR _____/______/______	AGE ____	MARITAL STATUS **(Please Circle)** S M Common Law D W Sep

4. **NAME OF NEXT OF KIN OR FRIEND**

NAME ____________________ TELEPHONE ____________________ ADDRESS ____________________

RELATIONSHIP ____________________

5. **HEALTH CARD #** (10 DIGITS) | | | | | | | | | | |

VERSION CODE: | | | 1 OR 2 LETTERS FOLLOWING THE NUMBER OR ON THE BOTTOM RIGHT OF THE CARD

PLEASE BRING YOUR HEALTH CARD WITH YOU

PATIENT'S EMPLOYER NOW:____________________ ADDRESS: ____________________

Semi Private Room $225 per day

☐ Insurance Coverage — I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim

☐ NO Insurance Coverage — I accept financial responsibility of all charges for preferred accommodations

Private Room $250 per day

☐ Insurance Coverage — I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim

☐ NO Insurance Coverage — I accept financial responsibility of all charges for preferred accommodations

Ward Room

☐ With valid OHIP Health Card

☐ No OHIP Health Card ☐ WSIB ☐ Out of Province $ 1,066 ☐ Out of Country $ 1,960

I accept financial responsibility for the basic accommodation charges if not covered by the Ministry of Health or WSIB

Insurance Information:

Policy Holder Name ____________________

Policy Holder DOB (DD/MM/YY)____________________

Insurance Company ____________________

Certificate Number ____________________

Policy/Group Number ____________________

Secondary Insurance:

Policy Holder Name ____________________

Policy Holder DOB (DD/MM/YY)____________________

Insurance Company ____________________

Certificate Number ____________________

Policy/Group Number ____________________

Note: PRHC does not assume any responsibility for patient valuables

Print Name: ____________________ Patient or Guarantor accepting financial responsibility

Signature: ____________________ Witness: ____________________ Date: ____________

Credit Card Information:

Credit Card Number: ____________________Exp. Date: ____________ M/C VISA AMEX

Card Holder Name: ____________________ Card Holder Signature: ____________________