Gaston Memorial Hospital
CaroMont Health

Pre-Registration Form

Please take a moment to complete this information. It will enable us to better assist you when you arrive. Please **E-mail** completed form to: Pre-Registration@gmh.org, **FAX** completed form to 704-834-2777, or you may call 704-834-2914 to pre-register by telephone.

Procedure:____________________ Procedure Date:__________

Diagnosis (Why are you having this procedure?)____________________

If accident, accident date & time:__________________Job Related?:________

Ordering Physician:__________________ Primary Care Physician:__________

Patient's Name: Last:__________First:__________Middle/Maiden:________Sex:____

Date of Birth:___/___/___ Social Security #: ____-____-____ Marital Status:______Race:____

Street Address:____________________________________

Mailing Address (if different)______________________________

City:__________________ State:__________ Zip Code:__________

Telephone: (Home) __________ (Cell)__________ (Work)__________

Employer:________________________ How Long Employed?:________

Employer Address:____________________________________

If insured: Name of Insurance Company:______________________________

Policy #:______________ Group #:__________ Verify Phone #:__________

Other Insurance Coverage: *circle one* (Secondary/Supplement/Liability/Worker's Compensation*)*

Name of Policyholder:____________________ Relationship to Patient:________

Date of Birth:____/____/____ Social Security #:____-____-____ Phone #:__________

Employer:________________________ Work #:______________

Employer Address:____________________________________

Name of Insurance Company:______________________________

Policy #:______________ Group #:__________ Verify Phone #:__________

If applicable:

Medicare #:__________________ Medicaid #:__________________

Medicare HMO? Name:__________________ ID #:______________

Emergency Contact:____________________ Relationship to Patient:________

Telephone: (Home)__________ (Cell)__________ (Other)__________

Religious Preference:__________ Primary Language:__________________

Do you have a Living Will?________ HealthCare Power of Attorney?__________

Please be aware that e-mail communication can be intercepted in transmission or misdirected. Your use of e-mail to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information by telephone or fax.