IMPORTANT

PLEASE COMPLETE THE ENCLOSED FORM AND RETURN IMMEDIATELY

The White Plains Hospital
Admitting Department
Davis Ave. at E. Post Road
White Plains, NY 10601
914-681-0600

Dear Patient:

We welcome the opportunity to be of service to you during your stay at White Plains Hospital. In order to expedite your admission, please complete this pre-admission form and return it to us at the above address, so that your admission record will be ready when you arrive.

Please bring all hospital insurance cards, current medicaid cards and completed insurance claim forms with you upon admission. We must have the social security and insurance policy numbers for both husband and wife where applicable. In addition, please check with your insurance carrier to see if you have routine nursery coverage on your policy. If there is no routine nursery coverage, an advance deposit of $1500.00 will be required for your newborn's care. If you have no insurance coverage, then an advance deposit of $4000.00 will be required for normal delivery and $4500.00 for C-Section.

Please be aware that almost all insurance companies now require pre-certification. Your insurance card should have the pre-certification information on it. Failure to comply will result in a reduction of your benefits. Please include your pre-certification reference number in the space provided on the front of this form. If you have any questions regarding your insurance coverage or the pre-certification process, please call the credit office at (914) 681-1016 and we will be happy to assist you.

The last thing that is required by your insurance company, is the addition of your newborn to your policy. In most cases you have 30 days after the birth to add them to your policy. This can be done either through your benefits' office at work or directly with your insurance company if you are not covered by a group policy.

The White Plains Hospital is your hospital and its only purpose is to serve you. It is a non-profit organization whose only "profits" can be improved services to the people of the community. Since this is your hospital, any comments concerning hospital services would be appreciated. Many of the improvements in our services have been a direct result of patient comments.

Sincerely,

Director of Admissions

Last First Middle

Patient Name:

Patient Address:

Home Phone:

Cell Phone:

E-Mail:

Date of Birth: Place of Birth:

Social Security Number: Preferred Language:

Maiden Name: Race: Ethnicity:

Patient's Employer:

Employer's Address:

Employer's Phone #:

Physician's Name: Expected Date of Admission:

Marital Status: Religion:

Last First Middle

Spouse's Name:

Address:

Phone:

Date of Birth:

Spouse's Social Security Number:

Name Baby Will Use:

Spouse's Employer:

Employer's Address:

Employer's Phone #:

Insurance Information

PATIENTS

Primary Insurance:

Insurance Company Name:

Insurance Company Address:

Insurance Company's Phone #: ( ) –

Policy Number:

Group Number:

Pre-Cert Reference #:

Secondary Insurance:

Insurance Company Name:

Insurance Company Address:

Insurance Company's Phone #: ( ) –

Policy Number:

Group Number:

Primary Care Physician:

Provider Name:
Print (First and Last):

Address:

Phone #: ( ) –

Pharmacy (Preferred):

Pharmacy Name:

Address:

Phone #: ( ) –

Advance Directives:

Do you have a health care proxy? (please circle) Yes or No

If yes: Proxy Agent Name:
Print (First and Last):

Address:

Phone #: ( ) –

If No: Are you interested in preparing a health care proxy?

Name:
Print (First and Last):

Address:

Phone #: ( ) –

Please Include copies of the health care proxy and insurance cards (front and back)