SHN
SCARBOROUGH HEALTH NETWORK

ADMISSION / PRE-ADMISSION QUESTIONNAIRE

OFFICE USE ONLY

UNIT NUMBER	ACCOUNT NUMBER	DATE OF ADMISSION
UNIT NUMBER	DATE OF PRE-REGISTRATION	
ATTENDING DOCTOR		

841028

PLEASE COMPLETE THIS FORM AND LEAVE IN YOUR SURGEONS OFFICE

HAVE YOU BEEN A PATIENT IN A HOSPITAL PREVIOUSLY? ☐ YES ☐ NO

NAME OF HOSPITAL _____ DATE OF ADMISSION _____

PATIENT'S LAST NAME	GIVEN NAMES	MAIDEN NAME / OTHER NAME

HOME ADDRESS - STREET, OR R.R NO.	TOWN OR CITY	POSTAL CODE	TELEPHONE - HOME

PROVINCE	AGE	SEX	MARITAL STATUS	DATE OF BIRTH	RELIGION	TELEPHONE - WORK
		☐ M ☐ F	☐ S ☐ SEP ☐ M ☐ DIV ☐ WID	DAY / MONTH / YEAR		

NEXT OF KIN (HUSBAND, WIFE, MOTHER ETC.)	ADDRESS	RELATIONSHIP	TELEPHONE HOME _____ WORK _____

NAME OF FAMILY DOCTOR	ADDRESS	TELEPHONE

HEALTH CARD NO	VERSION CODE (IF APPLICABLE)	EXPIRY DATE

IF THIS IS A WORKER'S COMPENSATION CASE, PLEASE COMPLETE BELOW (WSIB COVERS STANDARD WARD ACOMMODATION ONLY)

WORKERS COMPENSATION CLAIM NUMBER	DATE OF ACCIDENT	SOCIAL INSURANCE NUMBER

NAME OF EMPLOYER WHEN ACCIDENT HAPPENED

ADDRESS OF EMPLOYER	TELEPHONE NUMBER OF EMPLOYER

IF YOU ARE STAYING OVERNIGHT COMPLETE THE FOLLOWING INFORMATION BELOW

ACCOMODATION REQUESTED (PLEASE CHECK ONE ONLY)

☐ WARD (COVERED BY ONTARIO HEALTH INSURANCE)

☐ SEMI-PRIVATE $235.00
☐ PRIVATE $290.00
} COVERED BY PRIVATE INSURANCE OR PATIENT'S RESPONSIBLITY

***** PRICES TO CHANGE WITHOUT NOTICE *****

IF YOU HAVE INSURANCE BALANCE FOR PRIVATE OR SEMI-PRIVATE ROOM, PLEASE COMPLETE THE FOLLOWING SECTION

POLICY OR GROUP NO	CERTIFICATE OR IDENTIFICATION	DIVISION NO

NAME OF INSURANCE COMPANY	NAME OF INSURED	DATE OF BIRTH OF INSURED

RELATIONSHIP TO PATIENT	EMPLOYER OF INSURED	ADDRESS OF EMPLOYER

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Please Shred Upon Patient Discharge