OhioHealth

PATIENT REGISTRATION

PREADMISSION FORM

Marion General Hospital

Attention: Pre Services 278 Barks East Road, Marion, Ohio 43302 Fax: (740) 375.6439

Please complete this form and either fax or mail it to the above address/fax number as soon as possible. The information will be confirmed at the time of admission. Please include a copy of your health insurance card(s), both front and back sides. If you prefer, you may pre-register online by visiting **www.ohiohealth.com/pre-registration/**, or over the phone at **(740) 375.6436**.

FOR OB/MATERNITY ONLY	
DUE DATE	OBSTETRICS PHYSICIAN

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

CHURCH	DENOMINATION	NOTIFY CHURCH OF ADMISSION? ❒ YES ❒ NO	WOULD YOU LIKE TO OPT OUT OF THE FACILITY DIRECTORY? ❒ YES ❒ NO

********PLEASE READ: IF YOU OPT OUT OF THE FACILITY DIRECTORY, THE HOSPITAL WILL BE REQUIRED TO DENY YOUR PRESENCE IF ANYONE (INCLUDING FAMILY OR FRIENDS) ATTEMPTS TO CALL OR VISIT. YOU WILL NOT RECEIVE VISITORS, PHONE CALLS, FLOWERS OR MAIL.********

PATIENT/EMPLOYER DEMOGRAPHIC INFORMATION

SS NUMBER	NAME (LAST, FIRST, MI TITLE)

RACE ❒ AFRICAN AMERICAN ❒ ASIAN ❒ CAUCASIAN ❒ HISPANIC ❒ OTHER	DATE OF BIRTH	MARITAL STATUS	ADDRESS

CITY / STATE / ZIP	COUNTY	PHONE ( )	CELL PHONE ( )

MAY WE LEAVE YOU A PHONE MESSAGE ❒ YES ❒ NO	EMPLOYMENT STATUS ❒ FT ❒ PT	EMPLOYER / SCHOOL	ADDRESS

CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION

GUARANTOR INFORMATION

Complete only if patient is a minor.

RELATIONSHIP	NAME (LAST, FIRST, MI)	SEX ❒ M ❒ F

DATE OF BIRTH	MARITAL STATUS	ADDRESS	CITY / STATE / ZIP

MAY WE LEAVE YOU A PHONE MESSAGE ❒ YES ❒ NO	SS NUMBER	EMPLOYMENT STATUS ❒ FT ❒ PT	EMPLOYER / SCHOOL	ADDRESS

CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION

RELATIVE 1 INFORMATION

(i.e. spouse, parent, grandparent)

RELATIONSHIP	NAME (LAST, FIRST, MI)	SEX ❒ M ❒ F

SS NUMBER	DATE OF BIRTH	ADDRESS (complete if different from patient)	CITY / STATE / ZIP

PHONE ( )	EMPLOYMENT STATUS ❒ FT ❒ PT	EMPLOYER / SCHOOL	ADDRESS

CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION

RELATIVE 2 INFORMATION

(i.e. relative or friend)

RELATIONSHIP

NAME (LAST, FIRST)	ADDRESS	CITY/STATE/ZIP	PHONE ( )

INSURANCE INFORMATION - PRIMARY

PLAN NAME (NAME OF INSURANCE COMPANY)		
INSURED'S NAME/POLICY HOLDER		
CLAIM / POLICY / RECIPIENT NUMBER	GROUP / CASE #	GROUP NAME
CLAIM ADDRESS	CITY	
STATE	ZIP	PHONE NUMBER FOR BENEFITS OR CUSTOMER SERVICE ( )

INSURANCE INFORMATION - SECONDARY

PLAN NAME (NAME OF INSURANCE COMPANY)		
INSURED'S NAME/POLICY HOLDER		
CLAIM / POLICY / RECIPIENT NUMBER	GROUP / CASE #	GROUP NAME
CLAIM ADDRESS	CITY	
STATE	ZIP	PHONE NUMBER FOR BENEFITS OR CUSTOMER SERVICE ( )

FINANCIAL INFORMATION

BILLING

WHEN RECEIVING CARE AT ANY OHIOHEALTH FACILITY, YOU COULD RECEIVE STATEMENTS FROM THE FOLLOWING:

+ HOSPITAL
+ PHYSICIAN(S)
+ ANESTHESIOLOGIST(S)
+ RADIOLOGIST(S)

INSURANCE PATIENTS

CONTACT YOUR INSURANCE COMPANY TO OBTAIN YOUR BENEFITS PRIOR TO YOUR SERVICES.

+ YOUR INSURANCE COMPANY SHOULD BE ABLE TO PROVIDE YOU WITH THE FOLLOWING:

BENEFIT INFORMATION INCLUDING WHAT YOU CAN EXPECT THE OUT OF POCKET EXPENSE TO BE.

HOW AND WHEN TO ADD YOUR NEWBORN(S) TO YOUR INSURANCE POLICY. FOR MATERNITY PATIENTS.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR INSURANCE OR WANT TO MAKE ANY PRE-PAYMENTS ON YOUR ACCOUNT(S) PLEASE CONTACT THE FOLLOWING:

+ MARION GENERAL HOSPITAL - 740-375-6436

MEDICAID/CARESOURCE/MOLINA PATIENTS (MATERNITY ONLY)

PLEASE CONTACT YOUR CASEWORKER UPON DELIVERY OF YOUR NEWBORN(S). THIS WILL ENSURE THE NEWBORN(S) WILL BE ADDED TO YOUR OPEN MEDICAID CASE.

OHIOHEALTH WILL FOLLOW UP WITH THE COUNTY TO MAKE SURE YOUR NEWBORN(S) IS ADDED TO MEDICAID OR MEDICAID HMO.

SELF PAY PATIENTS

IF ADMITTED TO THE HOSPITAL DURING YOUR STAY, A FINANCIAL COUNSELOR WILL VISIT YOU TO DISCUSS PAYMENT OPTIONS ON ANY UNPAID BALANCE(S).

YOU CAN CONTACT FINANCIAL COUNSELING BEFORE YOU DELIVER TO DISCUSS PAYMENT INFORMATION:

+ MARION GENERAL HOSPITAL - 740-375-6436

FINANCIAL ASSISTANCE IS AVAILABLE TO THOSE WHO QUALIFY.