



PATIENT REGISTRATION  
PREADMISSION FORM

- DOCTORS HOSPITAL
- DUBLIN METHODIST HOSPITAL
- GRADY MEMORIAL HOSPITAL
- GRANT MEDICAL CENTER
- RIVERSIDE METHODIST HOSPITAL

Attention: Pre Services 5350 Frantz Road, Dublin, Ohio 43016 Fax: (614) 544.6483

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/](http://www.ohiohealth.com/pre-registration/) or over the phone at (614) 566.1515.

FOR OB/MATERNITY ONLY			
DUE DATE	OBSTETRICS PHYSICIAN	PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN
CHURCH	DENOMINATION	NOTIFY CHURCH OF ADMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO	WOULD YOU LIKE TO OPT OUT OF THE FACILITY DIRECTORY? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> OTHER	<input type="checkbox"/> ASIAN <input type="checkbox"/> HISPANIC	DATE OF BIRTH	MARITAL STATUS	ADDRESS
CITY / STATE / ZIP	COUNTY	PHONE ( )	CELL PHONE ( )	
MAY WE LEAVE YOU A PHONE MESSAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYMENT STATUS <input type="checkbox"/> FT <input type="checkbox"/> PT	EMPLOYER / SCHOOL	ADDRESS	
CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION		

GUARANTOR INFORMATION		RELATIONSHIP		NAME (LAST, FIRST, MI)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Complete only if patient is a minor.					
DATE OF BIRTH	MARITAL STATUS	ADDRESS	CITY / STATE / ZIP		
MAY WE LEAVE YOU A PHONE MESSAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	SS NUMBER	EMPLOYMENT STATUS <input type="checkbox"/> FT <input type="checkbox"/> PT	EMPLOYER / SCHOOL	ADDRESS	
CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION			

RELATIVE 1 INFORMATION		RELATIONSHIP		NAME (LAST, FIRST, MI)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
(i.e. spouse, parent, grandparent)					
SS NUMBER	DATE OF BIRTH	ADDRESS (complete if different from patient)	CITY / STATE / ZIP		
PHONE ( )	EMPLOYMENT STATUS <input type="checkbox"/> FT <input type="checkbox"/> PT	EMPLOYER / SCHOOL	ADDRESS		
CITY / STATE / ZIP	WORK PHONE ( )	OCCUPATION			

RELATIVE 2 INFORMATION		RELATIONSHIP			
(i.e. relative or friend)					
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:

- + DOCTORS HOSPITAL - 614-566-1515
- + DUBLIN METHODIST HOSPITAL - 614-566-1515
- + GRADY MEMORIAL HOSPITAL - 614-566-1515
- + GRANT MEDICAL CENTER - 614-566-1515
- + RIVERSIDE METHODIST HOSPITAL - 614-566-1515

### 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:

- + DOCTORS HOSPITAL - 614-544-2473
- + DUBLIN METHODIST HOSPITAL - 614-544-8330
- + GRADY MEMORIAL HOSPITAL - 740-615-1237
- + GRANT MEDICAL CENTER - 614-566-9611
- + RIVERSIDE METHODIST HOSPITAL - 614-566-5059

FINANCIAL ASSISTANCE IS AVAILABLE TO THOSE WHO QUALIFY.