

Maternity Pre-Admission Information

#1

Please complete this form as soon as possible, upon receiving from your doctor or midwife.					
Patient Name: <i>(print first, last)</i>				Date of Birth: <u> </u> / <u> </u> / <u> </u>	
Phone Number:			Alternate Phone Numbers:		
Mailing Address: <i>Street Name and Number</i>		<i>Apartment</i>	<i>City</i>	<i>Province</i>	<i>Postal Code</i>
Health Card #:		Military Regiment/Service Number:			
Name of Emergency Contact: <i>(print first, last)</i>					
Relationship to Patient:				Phone Number:	
Mailing Address: <i>Street Name and Number</i>		<i>Apartment</i>	<i>City</i>	<i>Province</i>	<i>Postal Code</i>
Family Physician: <i>(print first, last)</i>				Phone Number:	
INSURED RESIDENTS - ALL MATERNITY PATIENTS *rates subject to change without notice					
Please select the preferred accommodation of your choice					
<input type="checkbox"/> PRIVATE <small>(1 person/room) \$340.00 per day</small>		<input type="checkbox"/> SEMI-PRIVATE <small>(2 people/room) \$280.00 per day</small>		<input type="checkbox"/> PRIVATE OR SEMI-PRIVATE <small>(first available) \$340.00 or \$280.00 per day</small>	
<input type="checkbox"/> WARD <small>(4 people/room) Covered by your Provincial Insurance</small>				INITIALS _____	
<input type="checkbox"/> SELF PAY Signature of Patient Guardian _____ Date <u> </u> / <u> </u> / <u> </u>					
If you have Extended Health Insurance, please check with your insurance company to be certain of the coverage offered by your plan. You will be asked to pay for the charges not covered by your insurance on a credit card. Official receipt will be mailed. INITIALS _____					
INSURANCE INFORMATION	Primary Insurance		Secondary Insurance		
Name of Insurance Company					
Certificate Holder <i>(print first, last)</i>	Relationship to client		Relationship to client		
Policy / Group #					
Certificate / ID #					
<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Amex – Card Number: _____			Exp. Date: <u> </u> / <u> </u>		CW/CVC:
Name On Credit Card: <i>(print first, last)</i>		Signature: _____		Date: <u> </u> / <u> </u> / <u> </u>	
ADDITIONAL INFORMATION REQUIRED			Expected Delivery Date: <u> </u> / <u> </u> / <u> </u>		
Partner's Name: <i>(print first, last)</i>				Phone Number:	
Obstetrician Name: <i>(print first, last)</i>			Midwife Name: <i>(print first, last)</i>		
Delivering Physician Name: <i>(print first, last)</i>					
While you are in hospital, your baby's admission surname is attached to the mother's surname for safety and security reasons. Should you wish your baby's name to be changed, you may do so when you go online to register the birth with Service Ontario – instructions on how to do this will be given to you after your baby is born.					
Once you have completed this form please return by: FAX: (905) 830-5811 EMAIL: PreferredAccommodation@southlake.ca					

