Return Form To: Admitting Department
Peterborough Regional Health Centre
1 Hospital Drive
PETERBROUGH, ON K9J 7C6
705-743-2121, Ext. 3103 - Fax – 705-876-5107

PETERBOROUGH REGIONAL HEALTH CENTRE
BIRTHING PRE-ADMISSION FORM

ACCT. #_____

PLEASE complete & return this form at least 10 weeks before your expected date of delivery. Helps to ensure follow up on discharge.

Expected Date of Delivery: _____/_____/_____ (DAY/MONTH/YEAR) **Previous Patient at PRHC:** ☐ Yes ☐ No

Family Dr._____ **Attending Dr./Midwife:**_____

Expected Date of Discharge From Hospital: For Normal Vaginal Births: 24 hrs. **For Caesarean Births:** 48 hrs.

1. LAST NAME	ALL GIVEN NAMES **(no Initials) Underline** Name Used	ANY PREVIOUS LAST NAME AND MAIDEN NAME

2. HOME ADDRESS (STREET, R.R., BOX, APT.)	CITY/TOWNSHIP	POSTAL CODE	RELIGION

3. HOME TELEPHONE AREA CODE _____ - _____	DATE OF BIRTH: DAY MONTH YEAR _____/_____/_____	AGE ____	MARITAL STATUS **(Please Circle)** S M Common Law D W Sep

4. **NAME OF NEXT OF KIN OR FRIEND**

NAME _____ TELEPHONE _____ ADDRESS _____

RELATIONSHIP _____

5. **HEALTH CARD #** (10 DIGITS) | | | | | | | | | | | | **VERSION CODE:** | | 1 OR 2 LETTERS FOLLOWING THE NUMBER OR ON THE BOTTOM RIGHT OF THE CARD

PLEASE BRING YOUR HEALTH CARD WITH YOU

PATIENT'S EMPLOYER NOW:_____ ADDRESS: _____

Semi Private Room $255 per day

☐ Insurance Coverage — I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim

☐ NO Insurance Coverage — I accept financial responsibility of all charges for preferred accommodations

Private Room $300 per day

☐ Insurance Coverage — I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim

☐ NO Insurance Coverage — **I accept financial responsibility of all charges for preferred accommodations**

Ward Room

☐ With valid OHIP Health Card

☐ No OHIP Health Card ☐ WSIB ☐ Out of Province $ 1,044 ☐ Out of Country $ 2,088

I accept financial responsibility for the basic accommodation charges if not covered by the Ministry of Health or WSIB

Insurance Information:

Policy Holder Name _____

Policy Holder DOB (DD/MM/YY)_____

Insurance Company _____

Certificate / ID Number _____

Policy/Group Number _____

Name of Employer _____

Secondary Insurance:

Policy Holder Name _____

Policy Holder DOB (DD/MM/YY)_____

Insurance Company _____

Certificate / ID Number_____

Policy/Group Number _____

Name of Employer _____

Print Name: _____ Patient or Guarantor accepting financial responsibility

Signature: _____ **Witness:** _____

Date: _____

Note: PRHC does not assume any responsibility for patient valuables