

- Kishwaukee Community Hospital
- Valley West Community Hospital
- Hauser Ross Eye Institute and Surgicenter
- Unlimited Performance
- Kishwaukee Regional Rehab Center
- Kishwaukee Health Care, Hampshire

Physician: _____
Date of Service(s): _____ (or due date)
Type of Service: _____
Pre Cert/Authorization # _____

**PRE-REGISTRATION QUESTIONNAIRE**

*This form must be completed and returned to Kishwaukee Community Hospital to avoid possible cancellation or delay of your service(s).*

**PATIENT INFORMATION – PLEASE PRINT**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Cell \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed Maiden Name \_\_\_\_\_  
 Have you been a patient at this hospital before?  Yes  No Referring Physician \_\_\_\_\_

**GUARANTOR'S INFORMATION: SPOUSE OR LEGAL GUARDIAN**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Employer's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**NOTIFY IN CASE OF EMERGENCY (Not in the same household)**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**INSURANCE INFORMATION**

**INSURANCE #1 (PRIMARY)**

Insurance Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Phone No. \_\_\_\_\_  
 Group No. \_\_\_\_\_  
 Policy No. \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Social Security No. \_\_\_\_\_

**Please forward a copy of your insurance card for this visit.**

**INSURANCE #2 (SECONDARY)**

Insurance Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Phone No. \_\_\_\_\_  
 Group No. \_\_\_\_\_  
 Policy No. \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Social Security No. \_\_\_\_\_

**Please forward a copy of your insurance card for this visit.**

I hereby authorize Kishwaukee Health System to release to my insurance companies, employer insurance groups, health plans, Medicaid/Medicare program, its insurance carriers or intermediaries, and authorized external review agencies, any medical records or other information concerning this treatment, including this preregistration records, to process insurance claims and conduct utilization review procedures.

\_\_\_\_\_  
 (Patient or Guardian) Date: \_\_\_\_\_

\_\_\_\_\_  
 (Relationship) Witness: \_\_\_\_\_