

PreAdmission Form
Shands Healthcare at the University of Florida

The information you provide on this form will be directed to the Admissions Department and will be used to expedite the registration process on the day you are admitted or receive services at Shands UF. This information is treated as confidential. If you prefer to submit your information via e-mail or if you have questions about filling out the form below, please contact Admissions at (352) 265-0477.

Section 1. Visit Specific Information

What is your scheduled date of Admission or Surgery?: _____

Who is your attending physician?: _____

Who referred you to Shands HealthCare?: _____

Section 2. Patient Information

Were you born at or have you ever been treated at Shands @ the University of Florida? Yes
No

If Yes, do you know your Medical Record Number?

Under which name were you treated?

Last Name: First Name: Middle Initial:

Last Name: First Name: Middle Initial:

Address:

City: State: Zip:

Phone: Birthdate: (MM/DD/YYYY)

Social Security:

Marital Status: Ethnic Group:

Patient Employer:

Address:

City: State: Zip:

Phone: Ext.

Employment Status: (Fulltime, Part-time, Temporary, etc.)

Department: Occupation:

insurance company is required prior to admission. Failure to do this may result in a penalty against your benefits. To help you complete this section you may want to refer to your insurance card.

Name of Primary Insurance Company:

Address:

City: State: Zip:

Group Number:

Policy/Subscriber Number:

Insurance Phone Number: Ext.

Are you the subscriber? (A subscriber is the person who carries the insurance policy) Yes (if yes, SKIP to Section 3a)
No (if No, complete Subscriber Information)

If No, what is your relationship to the subscriber?

Subscriber Information

Last Name: First Name: Middle Initial:

Address:

City: State: Zip:

Phone: Birthdate: (MM/DD/YYYY)

Social Security:

Sex: Female
Male

Subscriber Employer:

Address:

City: State: Zip:

Phone: Ext.

