KEARNEY REGIONAL
Medical Center

PRE-ADMISSION SHEET

ATTENTION: Admitting/Registration Department

PLEASE PRINT LEGIBLY AND USE LEGAL NAMES

Doctor: ______________________ **Due Date:** ______________________

PATIENT INFORMATION ***(Mother of Newborn):***

Name:

______________________ ______________________ ______________________
First *Middle* *Last*

Social Security # ______________________ Birth Date:______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Phone: ______________________ Work Phone: ______________________

Home Address: ______________ ______________ ______________ ________
Street *City* *State* *Zip*

County: ______________ Email: ______________________________

Employer: ____

Employer's Address: ______________________________________ ________
Street *City* *State* *Zip*

Religious Preference: ______________ Name of Church: ______________

Primary Care Physician: ______________________

Do you have an Advanced Directive? ☐ Yes ☐ No ☐ More information?

(If yes, please bring a copy with you if you want it in your medical record)

Not a Permanent Part of Medical Record

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FATHER

If the mother is unwed at conception, birth, or any time between and the biological father's name is added to the birth certificate, both parents must sign an Acknowledgment of Paternity in the presence of a notary public. Identification is required. This must be completed and notarized at the Hospital.

FATHER OF NEWBORN:

Name:

______________________ ______________________ ______________________
First *Middle* *Last*

Social Security # ______________________ Birth Date: ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Phone: ______________________ Work Phone: ______________________

Home Address: ______________________ ______________________ ______________________ ______________________
Street *City* *State* *Zip*

Employer: ____

Employer's Address: ____ ______________
Street *City* *State* *Zip*

NEAREST RELATIVE (if different from above):

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Work Phone: ______________________

EMERGENCY CONTACT (if different from above):

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Work Phone: ______________________

Not a Permanent Part of Medical Record

Hospital: 804 22nd Ave Kearney, NE 68845
Hospital Main: (308) 455-3600
Hospital Fax: (308) 455-3950

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IMPORTANT INSURANCE INFORMATION:

(It is your responsibility to contact your insurance for precertification prior to admission).

Primary Ins. ______________________________
Address: ______________________________
Person Insured: ______________________________
Policy #/Group #: ______________________________
Certificate/Subscriber #: ______________________________
Employer or Union: ______________________________
Pre-certification #: ______________________________
Person Contacted: ______________________________

Secondary Ins. ______________________________
Address: ______________________________
Person Insured: ______________________________
Policy #/Group#: ______________________________
Certificate/Subscriber #: ______________________________
Employer or Union: ______________________________
Pre-certification #: ______________________________
Person Contacted: ______________________________

Newborns Primary Care Physician:

Clinic: ______________________________

Physician's Name: ______________________________

Location: ______________________________

Phone #: ______________________________

NEWBORN INSURANCE:

Newborn's Insurance:

Primary Ins. ______________________ Secondary Ins. ______________________________

Medicaid (Title XIX) Case #: ______________________________

Medicare #: ______________________________

Please bring insurance I.D, card(s) with you so a copy can be made to avoid delay in payment of claims

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