



**Women & Children's
Hospital of Buffalo**
A Kaleida Health Facility

Pre-admission Questionnaire

Please print all information clearly

REASON FOR ADMISSION						
SCHEDULED ADMISSION DATE		ADMITTING PHYSICIAN			PEDIATRICIAN	
PATIENT NAME (Last, First, Middle)			PATIENT'S SOCIAL SECURITY NUMBER		RELIGION	RACE
SEX		AGE				
ADDRESS (Street Name and Number)				CITY		STATE
ZIP						
PHONE NUMBER	EMERGENCY PHONE NUMBER		PATIENT'S PLACE OF BIRTH (CITY)		DATE OF BIRTH	ANY PRIOR LAST NAME FOR PATIENT
FATHER'S NAME (Last, First, Middle)				FATHER'S SOCIAL SECURITY NUMBER		FATHER'S DATE OF BIRTH
FATHER'S ADDRESS IF DIFFERENT			CITY	STATE	ZIP	FATHER'S PHONE NUMBER
MOTHER'S NAME (Last, First, Middle)			MOTHER'S MAIDEN NAME		MOTHER'S SOCIAL SECURITY NUMBER	
MOTHER'S DATE OF BIRTH						
MOTHER'S ADDRESS IF DIFFERENT			CITY	STATE	ZIP	MOTHER'S PHONE NUMBER
IF PARENTS ARE DIVORCED OR SEPARATED, WHO HAS CUSTODY?				IF PARENTS ARE DIVORCED OR SEPARATED, WHO HAS FINANCIAL RESPONSIBILITY?		
<input type="checkbox"/> FATHER		<input type="checkbox"/> MOTHER		<input type="checkbox"/> FATHER		<input type="checkbox"/> MOTHER
DOES SOMEONE OTHER THAN PARENT HAVE LEGAL CUSTODY OF THE PATIENT? <i>If so, please indicate below:</i>				NAME		
				ADDRESS		
DOES THE PATIENT HAVE MEDICAL INSURANCE?		DOES THE PATIENT HAVE DENTAL INSURANCE?		ADDRESS OF INSURANCE PLAN:		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				
TYPE OF MEDICAL INSURANCE FOR PATIENT				TYPE OF DENTAL INSURANCE FOR PATIENT		
WHO CARRIES THIS INSURANCE? (Name of subscriber)				RELATIONSHIP TO PATIENT		
ADDRESS FOR SUBSCRIBER IF DIFFERENT				CITY		STATE
ZIP						
INSURANCE I.D. NUMBER OR SUBSCRIBER SOCIAL SECURITY NUMBER			GROUP NUMBER		AUTHORIZATION NUMBER	
MEDICAID I.D. NUMBER (If applicable)			SEQUENCE NUMBER			
COMMENTS						
<p>If you are not sure that your insurance company requires a referral or pre-certification, please call the provider relations department of your insurance company.</p> <p>If you have any questions or would prefer to pre-admit by phone, please contact the call center at (716) 859-1234 or fax (716) 859-8545.</p>						

FROM

PLEASE
PLACE
STAMP
HERE

 **Kaleida Health**
Pre-Registration Call Center
726 Exchange St. Suite 208
Buffalo, NY 14210