CANYON VISTA
MEDICAL CENTER

5700 E. Hwy. 90
Sierra Vista, AZ 85635

Phone: 520-263-2000

PRE-ADMITTING INFORMATION

PRE-ADMISSION INFORMATION FORM

This is your "Pre-Admission" form. Please complete and return it to us as soon as possible. After filling out the form, detach along the perforation, fold at the center, staple at bottom and mail.

TIME AND PLACE OF ARRIVAL

You will be admitted through the main lobby. Check in at the information desk, after hours go directly to the client services desk.

INTERVIEW BY CLIENT SERVICES STAFF

Most of your registration information will be obtained from your Pre-Admission record. There are a few details remaining to be completed at the client services office in person, such as: assignment of your hospital account number, securing your signature, copying your photo ID and insurance card, etc.

When you check in at client services, registration should cause no more than a few minutes delay.

CLOTHING AND VALUABLES

We suggest that you bring only personal items such as toilet articles, dressing robe, slippers and other small items as needed.

> The hospital does not accept responsibility for money or articles of value kept in your room. If you find it unavoidable to bring valuables, please inform the client service office for information regarding their safekeeping. Cash kept in your room should be limited to $5.00.

YOUR HOSPITALIZATION INSURANCE

Certain commercial policies allow an assignment of benefits, permitting the insurance company to pay its portion of the bill directly to the hospital. With other policies, the patient pays the bill and is reimbursed by the insurance company after it receives proper claim forms and a hospital expense statement.

Your questions on insurance procedures should be cleared with the client services or financial office as soon as possible so that delays may be avoided when you are ready to leave.

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Pre-Admission Form

Please print or type all information

Patient's Legal Name (Last, First, Middle)				Patient's Social Security Number
Mailing Address				Home Phone #
Date of birth	Marital Status	Race	Religious Preference	Visit from Clergy? Yes No
If married, Spouse's Name (Last, First, Middle)			Spouse's Date of Birth	Spouse's Social Security Number
If not married, Name of nearest relative or friend (give relationship)			Address	Home Phone #
Who is the primary insured?				
Patient's employer, occupation, address and phone number. (If Military, what is your rank?)				
Spouse's employer, occupation, address and phone number. (If Military, what is sponsor's rank?)				
Insurance company name and mailing address				
Insurance ID number and Group number				
Name as it appears on insurance card			Effective date of insurance	
Estimated Due Date	Admitting Physician	Primary care Physician	Have you been a patient at CVMC?	Date of last period

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