GRAND RIVER HOSPITAL
Advancing Exceptional Care

PATIENT LABEL

ADMISSION FORM

Admit date:

PLEASE NOTE: 1. Surgical patients report to Ambulatory Registration. Bring Health Card to hospital.
2. Obstetrical patients register at the Childbirth Unit on 4D North, any time of the day.

PATIENT'S PERSONAL INFORMATION			
Last name	First name	Prior surname(s)/ maiden name	❒ Male ❒ Female ❒ _____
Address	City	Postal Code	
Home phone #	Business phone # and ext.	May we use these numbers to contact you / leave a message? ❒ No ❒ Yes	
Family doctor	Surgeon	**Allergies**	
Age	Date of Birth (year / month / day)	Have you been a patient in any Health Care Facility for > 12 hrs in the last 12 months? ❒ No ❒Yes _____ ❒ Not interviewable	
Name of contact in case of emergency (spouse, parent, guardian, guarantor, etc.)		Relationship to patient	
Address ❒ Same as above, or	Home phone	Business phone # and ext.	
Is this admission due to pregnancy? ❒ No ❒Yes	E-mail address		
Please state which pregnancy this is:	Obstetrician / Midwife		

PATIENT RESPONSIBILITIES:

- I understand that I am responsible and liable for all the costs incurred during my or the below noted patient's stay which are not covered by valid Provincial Healthcare Insurance i.e. OHIP, I further agree to pay all additional charges on discharge.
- **I understand that the hospital will bill my insurance company but that responsibility for full payment remains with me.** It is my responsibility to verify my coverage with my Insurance carrier and Grand River Hospital assumes no responsibility for verifying my insurance coverage. I assign all benefits payable from my Insurance claim to Grand River Hospital.
- **I understand that in the event Grand River Hospital is unable to reach me following discharge due to invalid contact information i.e. Invalid address or phone changes that Grand River Hospital reserves the right to access this information via agencies.**
- If I request a private room but I am placed in semi-private, the cost for semi-private will be applied. Likewise, if I am placed in a private room while requesting a semi-private, the charges for semi-private will be applied.
- **Any request to change your accommodation must be confirmed in writing, by contacting the Registration clerk.**
- **I authorize Grand River Hospital to release information requested by my insurance company or agencies associated with the recovery of due funds.**
- **Rates are subject to change.**

Please check ONE box only:

1st CHOICE	RATES	INITIALS	2nd CHOICE	RATES	INITIALS
☐ WARD/ covered by Valid OHIP	NO CHARGE		☐ WARD/ covered by Valid OHIP	NO CHARGE	
☐ SEMI-PRIVATE	$300/DAY		☐ SEMI-PRIVATE	$300/DAY	
☐ PRIVATE	$350/ DAY		☐ PRIVATE	$350/DAY	

PLEASE SIGN and DATE BELOW

Patient/ Guardian/ Substitute Decision Maker Signature:

Date ____/____/____
Year / Month / Date

Name of Responsible Party / Patient or Policy Holder _____

Signature: _____

Interviewed by Staff Signature: _____ Staff Name: _____
Extension:_____

PLEASE SEE NEXT PAGE FOR INSURANCE DETAILS

SEE OVER →

GRAND RIVER HOSPITAL
Advancing Exceptional Care

PATIENT LABEL

HEALTH INSURANCE INFORMATION

Is the patient covered under Ontario Health Insurance Plan? ❒ No ❒ Yes Last name on Health Card:	Health Insurance Number	Version code

Do you have supplementary insurance for semi or private coverage? ❒ No ❒ Yes
PLEASE COMPLETE if you have supplementary insurance for all Day Surgery, Inpatient and Outpatient Procedures.

If yes, name of 1st insurance company	1st Policy, Group, or Contract # :	1st Certificate or I.D. #:
Insurance Policy in name of ❒ Patient ❒ Other—please complete below		
Name	Relationship to patient	
Insurance coverage provided by employer ❒ No ❒ Yes		
Employer's name	Employer's address	
2nd Insurance Company Name:	2nd Policy, Group, or Contract # :	2nd Certificate or I.D. #
2nd Insurance Policy in name of ❒ Patient ❒ Other	Name:	Relationship to patient

WSIB INFORMATION

Is this admission because of a work-related injury? ❒ No ❒ Yes—Employer's name _____ Employer's address _____	Date of injury year / month / day
	Employer's telephone number (_____) _____
If yes, claim number	Social Insurance Number

OUT OF PROVINCE INFORMATION

Address of province of origin _____ _____ Home phone number (_____) _____ Business phone number (___) _____	Is this: ❒ Temporary move? ❒ Permanent move?
	Provincial Health Care Number
Expiry Date _____	Reason here ❒ Vacation ❒ Medical Referral ❒ Temporary employment ❒ Other _____

Is this admission the result of a motor vehicle accident? ❒ No ❒ Yes

Method of Payment

CREDIT CARD INFORMATION — if OHIP or private insurance does not cover all charges, your credit card will be charged based on information completed below.

❒ VISA

❒ MASTERCARD

Name of card holder (please print) _____

Account number _____

Expiry date _____

Signature _____