The Good Samaritan Hospital GSH

Maternity Pre-Admission

PLEASE FILL IN INFORMATION COMPLETELY……. THANK YOU !

Patient's Name ____________________ Maiden Name ____________
Address ____________________ City ____________
State ________ Zip Code ________ Telephone # (   ) ____________
Date of birth ________ Birth Place (State) ________ Marital Status (circle one) S M D W
Social Security Number ____________ Race ____________
Religion ____________ Church you Attend ____________
Employer ____________ Full or Part time ____________
Employer's Address ____________ City ____________
State ______ Zip Code ______ Telephone Number (   ) ____________
Name of Baby's Father ____________________
Date Birth ____________ Social Security Number ____________
Address if Different ____________ City ____________
State ________ Zip Code ______ Telephone Number (   ) ____________
Employer ____________________ Full or Part time ____________
Employer's Address ____________________ City ____________
State ______ Zip Code ______ Telephone Number (   ) ____________
Emergency contact (other than Spouse) ____________________
Address ____________________ City ____________
State ______ Zip Code ______ Telephone Number (   ) ____________
Relationship to Patient ____________________
Attending Doctor ____________ Family Doctor ____________
Due Date ______ Do you want your Admission Published in Newspaper (Circle) Yes No

*** Please Read & Fill out Insurance Information Carefully ***

____ Capital Blue Cross & Blue Shield Insurance Information:
Subscriber's Name ____________ Contract # ________ Group # ________
Blue Cross other than Capital ____________________State ____________
____ Medical Assistance: Recipient # ____________ Card Issue # ____________
____ Self Pay Patients: **If no insurance, a deposit of $1,000.00 is required prior to due date**.

Please contact Insurance Verification at (717) 274-9732

____ Other Insurance Information: Insurance Name & Co. ____________________
Address____________________________________
Subscriber's Name & Social Security # ____________________

Insurance Forms must be submitted to the Hospital prior to hospital admission.

Date Completed ____________ Signature____________________

After you have completed this form, return it to the receptionist, or mail to

Good Samaritan Hospital
Admitting Office
P.O. Box 1281, 4th & Walnut Sts.
Lebanon, PA 17042-1281