PRE-REGISTRATION FORM

Lima Memorial HEALTH SYSTEM
Affiliate of ProMedica

REGISTRATION DETAILS

Service to Register for
☐ Radiology ☐ Laboratory ☐ Surgery ☐ Obstetrics
☐ Cardiac Treatment ☐ Women's Health ☐ Other

Procedure(s)

Date of Service ___ / ___ / ___ (If childbirth, list the expected due date)
Month / Day / Year

Are you allergic to Latex? ☐ Yes ☐ No

Do you have a living will or Durable Power of Attorney for Medical Care? ☐ Yes ☐ No

PATIENT CONTACT INFORMATION

Name
(as it reads on photo ID)

Address
Street | City | State | Zip Code

Phone Number

Email

PATIENT PERSONAL INFORMATION

Gender ☐ Male ☐ Female

Marital Status

Social Security Number

Date of Birth ___ / ___ / ___
Month / Day / Year

Race

Ethnicity

Employment Status

Employer

OPTIONAL: Religion / Church Affiliation

NEXT OF KIN / EMERGENCY CONTACT INFORMATION

Name
(as it reads on photo ID)

Check box if address is same as patient ☐

Address

Street | City | State | Zip Code

Phone Number

Relationship to Patient

PRIMARY INSURANCE INFORMATION

Insurance Provider

Benefit Plan ☐ HMO ☐ PPO

Policy / ID Number

Group Number

Claims Address

Street | City | State | Zip Code

Phone Number

Insurance Card Copies Attached ☐

SECONDARY INSURANCE INFORMATION (if needed)

Insurance Provider

Benefit Plan ☐ HMO ☐ PPO

Policy / ID Number

Group Number

Claims Address

Street | City | State | Zip Code

Phone Number

Insurance Card Copies Attached ☐

PHYSICIAN / PROVIDER INFORMATION

Ordering Physician / Provider

Family Physician / Provider

Please fax completed forms to 419-221-6148.