Pre-Admission Registration/Accommodation Form

This form is to be provided to Quinte Health

Last Name	First Name (as per health card)	Phone #	Provincial Health Card #	
Mailing address		**City**	**Province**	**Postal code**

Birthdate DD/MM/YYYY	Age	Religion	Marital Status S/CL/M/D/SEP/W	Former Name

Family Physician	Attending Physician	Due Date DD/MM/YYYY

Next of Kin	Relationship	Address	Phone #
Alternate Contact	**Relationship**	**Address**	**Phone #**

Preferred Accomodation Request (initial)			
WARD	**SEMI PRIVATE**	**PRIVATE**	I understand that Quinte Health is NOT responsible for my personal effects that are lost, stolen or damaged while in hospital.
_____	_____ **$220.00 per day**	_____ **$260.00 per day**	

The undersigned patient/guarantor are financially responsible for all hospitalization charges not covered by the named insurance company or any other agency. I understand that I am responsible for paying all outstanding charges and I agree to pay the balance to Quinte Health. I understand that I am responsible for contacting my insurance provider regarding my coverage and that Quinte Health is not responsible for knowing what my insurance will pay. The hospital reserves the right to add applicable charges without further notice and the right to bill insurance companies in accordance with hospital policy. I also understand that all rates are subject to change without notice and I accept responsibility to pay those rates. My signature below indicates that I have read all the information on this agreement form and understand my responsibilities and that of Quinte Health.

Primary Insurance Policy

Name of Policy Holder	Employer	Group/Policy #	ID/Certificate #

Secondary Insurance Policy (if applicable)

Name of Policy Holder	Employer	Group/Policy #	ID/Certificate #

I assign Quinte Health all hospital benefits payable from this claim or so much thereof as may serve to satisfy my indebtedness or that of my dependent. I authorize Quinte Health to release my information required to settle this claim to the above named insurer.

Date _____ Signature_____

Date _____ Quinte Health Witness_____