St. Joseph's
Healthcare Hamilton

REGISTRATION FORM

Obstetrician ....
Midwife ....
Family Physician ....
Baby's Caregiver ....
EDD ....

Mr ☐ Miss ☐ Mrs ☐	Patient	Surname	First	Middle

Home Address	Apt. or Unit No.

City	Prov.	Postal	Home Phone ( )	Business Phone ( )

Date of Birth (year / month / day)	Age	Sex	Maiden or Alternate Name	Religion

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐	Name Church

Employment Status: Not currently employed ☐ Self employed ☐ Full time ☐ Part time ☐ Retired ☐

Patient's Employer	**Employee Number**
Employer's Address	**Patient's Social Insurance No.**

Previous Patient Yes ☐ No ☐ If yes, approximate date

Please Note: **You are required to use your legal name on health records. If you have been treated at St. Joseph's Healthcare Hamilton under a different name, please show this second name as an alternate name.**

First Contact in Case of Emergency

Name of Next of Kin. (Please list patient's closest relative, e.g. spouse, parent)	Relationship to Patient
Street Address Apt. No.	Home Phone
City Province Postal Code	

Second Contact in Case of Emergency

Name (Please complete of other than next of kin)	
Relationship to Patient	Phone

Provincial Health

Provincial Insurance Number		Version Code	Expiry Date
Exact Name from Provincial Health Card			

WCB

Was condition or injury work related			
If yes, complete last two lines	Claim No.	Date of Accident (year / month / day)	
Name of employer at time of accident			

PD 8339 (2013-05)

St. Joseph's Healthcare Hamilton

PREFERRED ACCOMMODATION REQUEST FORM

Provincial Health care provides standard ward coverage only. If you would like to request preferred accommodation (Semi-Private or Private), you will be required to provide additional insurance information or a deposit for the additional charges on admission to the Hospital.

Do you have additional insurance coverage for semi-private or private accommodation? **YES** ☐ **NO** ☐ **UNSURE** ☐

If yes, please complete the following:

Patient Employment and Insurance Information

Employer Name	Full / Part time / Retired	Employer Address
Name of Insurance Company	Insurance Group / Policy No.	
Certificate / Identification No.	Division / Section No.	Social Insurance No.

Please complete, if benefits are carried through your Spouse, Parent or Guardian

Employer Name	Employer Address	
Name of Insurance Company	Insurance Group / Policy No.	
Certificate / Identification No.	Division / Section No.	
Subscriber's Name	Subscriber's Date of Birth	Social Insurance No.

I wish to make the following request for Preferred Accommodation:

Ward ☐ (Covered by OHIP) **Semi-Private** ☐ (Currently $240.00/day) **Private** ☐ (Currently $270.00/day) **In the event a private room is not available I request a semi-private @240.00/day** ☐

I understand that when I request Preferred Accommodation, I am responsible for all charges not covered by my Insurance. It is the Patient's responsibility to confirm insurance coverage prior to admission.

Date:____________________ Signature of Patient/SDM: ________________________________

Signature of Admitting Clerk: ______________________________

I do not wish to make a specific request for Preferred Accommodation at this time.

However, upon admission if the hospital is able to provide me with a Semi-Private or Private room, I authorize the hospital to bill my insurance for reimbursement.

Date:________________ Signature of Patient/SDM (Substitute Decision Maker): __________________________

Please be advised that the Hospital cannot guarantee that your requested accommodation will be available when you are admitted.