Transfer Tape

Perforation

MAILING INSTRUCTIONS: FOLD THIS PAGE IN HALF, REMOVE PROTECTIVE TAPE, SEAL AND DROP IN MAIL TO THE PROSPECTIVE PATIENT:

Since the details of admittance to any hospital are time consuming and often bothersome to the patient, would you kindly provide the CONFIDENTIAL pre-admission information below. Please fold, seal and mail this self-addressed postage paid form to us as soon as possible.

We want to make sure your stay in our hospital is as pleasant and comfortable as possible.

Sincerely yours,
LEHIGH VALLEY HOSPITAL

MATERNITY ADMISSIONS ONLY **PLEASE PRINT**

Patient Information

Approximate Due Date: _______ / _______ / _______ Attending Doctor: ______________________

Patient's Name: ______________________ (Last, First, M.I.) Maiden Name: ______________________

Birth Date: _______ / _______ / _______ Social Security Number: _______ - _______ - _______ Family Doctor: ______________________

Patient's Address: ______________________ (Street, City, State, Zip) Patient's Phone: ________ - ________ - ________

County: ______________________ Marital Status: (Circle One) Married Single Widowed Divorced Separated

Religious Denomination: ______________________ Name of Church: ______________________

Would you like your congregation to be aware of your admission? ❒ Yes ❒ No

Patient's Employer: ______________________ Occupation: ______________________ ❒ Full Time ❒ Part Time

Employer's Address: ______________________ (Street, City, State, Zip) Employer's Phone: ________ - ________ - ________

Name of Spouse: ______________________ (Last, First, M.I.) Birth Date: _______ / _______ / _______ Social Security Number: _______ - _______ - _______

Perforation

Spouse's Employer: ______________________ Occupation: ______________________ ❒ Full Time ❒ Part Time

Employer's Address: ______________________ (Street, City, State, Zip) Phone: _______ - _______ - _______

Emergency Contact

Person to Contact in Case of Emergency: ______________________ (Last, First, M.I.) Phone: _______ - _______ - _______

______________________ (Street, City, State, Zip) Relationship to Patient: ______________________

Insurance Information

Name of Insured: ______________________ Birth Date: _______ / _______ / _______ Relationship: ______________________

Name of Insurance: ______________________ Plan No.: ______________________ Phone: _______ - _______ - _______

Policy, Agreement or ID Number: ______________________ Group Number: ______________________

Insurance Address: ______________________

Name of Insured: ______________________ Birth Date: _______ / _______ / _______ Relationship: ______________________

Secondary Insurance: ______________________ Plan No.: ______________________ Phone: _______ - _______ - _______

Policy, Agreement or ID Number: ______________________ Group Number: ______________________

Insurance Address: ______________________

We will be glad to assist you in making plans for admission to LEHIGH VALLEY HOSPITAL.
If you have any questions, please call 610-402-8064 Monday-Friday between 10:00 A.M. and 5:00 P.M.

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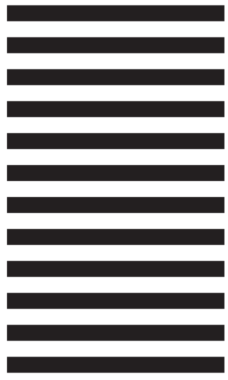

BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 1022 ALLENTOWN, PENNSYLVANIA

POSTAGE WILL BE PAID BY ADDRESSEE

PATIENT ACCESS SERVICES
LEHIGH VALLEY HEALTH NETWORK
2100 MACK BLVD FLR 4
ALLENTOWN, PA 18103-9988

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