



SHORE MEMORIAL HOSPITAL

Somers Point, NJ 08244

ACCESS MANAGEMENT PRE ADMISSION INFORMATION FORM

Have you previously had services at Shore Memorial Hospital? Yes No

VISIT INFORMATION

Physician: _____ Date of Service: ____/____/____

Procedure Being Done: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Int: _____ Suffix: _____

Date of Birth ____/____/____ Social Security #: _____ Maiden Name: _____

MAILING ADDRESS

Street: _____ Apt #: _____ Phone Number: (____) _____

City: _____ State: _____ Zip Code: _____

PERSONAL INFORMATION

Marital Status Single Married Separated Divorced Widow

Race: _____ Ethnicity: _____ Religious Preference: _____

Primary Language: _____ Will you need an interpreter Yes No

Living Will Yes No on File at Shore Memorial Organ Donor Card Yes No

EMPLOYMENT INFORMATION

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: (____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: (____) _____ Cell: (____) _____ Work: (____) _____

Is the reason for your visit due to a workers compensation or auto accident? Yes No

If you answered **Yes**, please fill out parts **A & B**

If you answered **No**, please just fill out part **A**

PART A

Are you 65 years of age or older? Yes No Retirement Date (MM/YY) _____

Are you disabled Yes No Date of Disability (MM/YY) _____

Do you have End Stage Renal Disease Yes No Start date of Dialysis (MM/YY) _____



SHORE MEMORIAL HOSPITAL

Somers Point, NJ 08244

ACCESS MANAGEMENT PRE ADMISSION INFORMATION FORM

PART A (Con't)

PRIMARY INSURANCE

Subscriber Name: _____ SS#: _____ Date of Birth: ___/___/___

Insurance Company: _____ ID#: _____ Group#: _____
Insurance Phone# (____) _____

Occupation: _____ Employer: _____ Phone :(____) _____

SECONDARY INSURANCE

Subscriber Name: _____ SS#: _____ Date of Birth: ___/___/___

Insurance Company: _____ ID#: _____ Group#: _____
Insurance Phone# (____) _____

Occupation: _____ Employer: _____ Phone :(____) _____

ADDITIONAL INSURANCE

Subscriber Name: _____ SS#: _____ Date of Birth: ___/___/___

Insurance Company: _____ ID#: _____ Group#: _____
Insurance Phone# (____) _____

Occupation: _____ Employer: _____ Phone :(____) _____

PART B

<p>Workers Compensation</p> <p>Date of Accident: _____</p> <p>Where: _____</p> <p>Name of Employer _____ (At time of accident)</p> <p>Contact Person: _____</p> <p>Name of Insurance Comp: _____</p> <p>Claim Number: _____</p> <p>Adjustor Name: _____</p> <p>Adjustor Phone: (____) _____</p>	<p>Auto Accident</p> <p>Date of Accident: _____</p> <p>Where: _____</p> <p>Name of Insurance Comp: _____</p> <p>Policy Number: _____</p> <p>Claim Number: _____</p> <p>Adjustor Name: _____</p> <p>Adjustor Phone: (____) _____</p> <p>Case Manager: _____</p> <p>Case Manager Phone: (____) _____</p>
---	--



SHORE MEMORIAL
HOSPITAL

Somers Point, NJ 08244

**ACCESS MANAGEMENT
PRE ADMISSION INFORMATION FORM**

Your Email Address: _____

If you have questions, feel free to contact the Admissions Office at Shore Memorial Hospital at 609-653-3654.

Please return the complete form and copy of insurance card(s) to:

The Admissions Office
Shore Memorial Hospital
1 East New York Avenue
Somers Point, NJ 08244

OR fax to 609-653-3922