PMAG
Presbyterian Medical Anesthesia Group

ASHFORD HOSPITAL
EST. 1904

HRPLABS
HATO REY PATHOLOGY ASSOCIATES, INC

Registration Form

Preferred Pharmacy: Name _____ Place: _____

Section 1: Patient Information

Name: _____ _____ _____ _____ _____ _____
Last Name | Mother's Maiden Name | Name | Middle Initial | Married Last Name | SS Number | Email Address | Service Date

Date of Birth: Month:_____ Day:_____ Year:_____ Father's Name: _____ Mother's Name:_____

Mark with an (**X**) the room type of your choice (if admitted). Select: _____ Semi private _____Private _____Alumbra Maternity (LDPR) _____ Suite _____ Surgi Suite
Private rooms and suites have an additional charge, which your health plan does not cover; these rooms are subject to availability. Once payment is issued, the money will not be reimbursed.

¿Is this the first time that you receive our services? Yes: _____ No: _____ Last Visit Date: _____

Physical Address: _____
Urbanization | Number | Street | City | Country | Zip Code

Postal Address: _____
Urbanization | Number | Street | City | Country | Zip Code

Telephone: Home: (___) _____ Cellular: (___) _____ Additional: (___) _____

Type of delivery (if applicable): Normal ( ) Cesarean ( ) Marital Status _____ Age: _____ Weight: _____ Religion:_____

Employer: _____ Occupation: _____ Work Phone: (_____) _____ Ext. _____

Work Address:_____

Section 2: Spouse Information

#SS: _____ - _____ - _____

Driver's License #: _____ Telephone: (___) _____

Name: _____
Last Name | Mother's Maiden Name | Name | Middle Initial

Email Address: _____

Employer: _____ Occupation: _____

Work Phone: (___) _____ Ext._____

Work Address: _____

Date of Birth: Month: _____ Day: _____ Year: _____

Section 3: Guarantor Information

#SS: _____ - _____ - _____ Relationship with patient _____

Driver License #: _____ Telephone: (___) _____

Name: _____
Last Name | Mother's Maiden Name | Name | Middle Initial

Postal Address: _____
Urbanization | Number | Street

_____
City | Country | Zip Code

Employer: _____ Occupation: _____

Work Phone: (___) _____ Ext._____

Work Address: _____

Date of Birth: Month: _____ Day: _____ Year: _____

Email Address: _____

Section 4: Person to call in case of emergency

Name: _____ Relationship with Patient: _____ Telephone: (___) _____
Last Name | Mother's Maiden Name | Name

Physical Address: _____
Urbanization | Number | Street | City | Country | Zip Code

Section 5: Health Insurance Information

Primary Health Care Plan 1: _____ Subscriber: _____ Date of Birth:_____ _____

Secondary Health Care Plan 2: _____ Subscriber: _____ Date of Birth: _____

I certify that the information herein is true and that my health plan cover (if there is one) is active. If my health plan is expired/cancelled, and if I do not present a new health plan card, it is because I do not have medical insurance coverage for the services requested. In any case, I am responsible to pay for all of the services not covered/paid by my health plan. I was also instructed to contact service providers to obtain information regarding coverage, deductibles, co-payments, and/or prices of services.

I was instructed that Anesthesia, Pathology, Radiologist and Physician services are independent and are not included in the hospital bill. These services include, but are not limited to: anesthesia for surgical procedures, epidural analgesia for child birth, and interpretation of arterial blood gases, among others. Anesthesia services may include other medical services such as: intubation, CPR and central line.

If during the pre-admission process it is established that you require such services, you will be referred for a medical evaluation and for a counseling interview regarding coverage. Anesthesia and Pathology Offices are located in the first floor of the hospital, where you must pay your bill.

You are responsible for calling these offices for information regarding: deductibles, coverage, additional studies and/or costs of services.

_____ _____ _____
Name of Patient or Guarantor (print) | **Signature of Patient or Guarantor** | **Date (Month/Day /Year)**

Signature of HOSPITAL Staff _____ Date _____

Signature of ANESTHESIA Staff _____ Date _____

Signature of PATHOLOGY Staff _____ Date _____