Brookings HEALTH SYSTEM

300 22nd Ave
Brookings SD, 57006
Phone: 605 696-9000 Fax: 605 696-8889

Preregistration form

Instructions:

1. Please print clearly and complete all information on all three pages.
2. If you require assistance in completing this form, please call the Business Office at 696-9000.
3. Please remember to bring your insurance identification card when you arrive at the hospital
4. **Please mail this form to the Brookings Health System Business Office.**

Patient Information

Appointment date: _____ Type of Service: □ Surgery □ Scheduled Test □ Other
Patient Name_____ (last name, first name, middle name) Maiden/Other Name _____ Birth date_____/_____/_____
Mailing Address _____ County Patient Resides:_____
State_____ Zip Code_____ Home Phone #(___) _____
Marital Status ❑Divorced ❑Married ❑Single ❑Widowed ❑Unknown
Ethnicity ❑Hispanic ❑Non-Hispanic
Language Preference_____
Soc Sec # _____
Employer_____
Mailing Address _____City_____State_____Zip Code _____
Employer Phone # ( )_____ Your Occupation _____
Referring Physician:_____Family/Primary Care Physician: _____
Do you have a living will? ❑Yes ❑No
Do you have a durable power of attorney for health care? ❑Yes ❑No If yes, please bring a copy when admitted.
Have you ever been a patient at the Brookings Health System? ___ Yes ___ No Under what Name?_____
Are you eligible for Medicaid? ___ Yes ___ No
Are you eligible for Indian Health Services? ___ Yes ___ No
Are you eligible for Veteran's Administration? Yes ___No __
Would you like to discuss financial assistance? ___ Yes ___No
Patient's Mother's Maiden name (to identify records) _____

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Spouse/Next of Kin

Legal Name _____
(last name, first name, middle name)
Mailing address_____City_____State_____ Zip Code _____
Home Phone #(____)_____
Work Phone #(____)_____ Soc Sec # _____Birth date_____/_____/_____
Next of Kin (PERSON WHO CAN MAKE MEDICAL DECISION FOR YOU IF YOU ARE UNABLE)
Legal Name _____
(last name, first name, middle name)
Mailing Address _____City_____State____ Zip Code _____
Home Phone # (__)_____Work Phone # (__) _____
Relationship to Patient_____

Guarantor (One person in household to receive billing statement)

If patient is 18 years or older they will be listed as guarantor.
If the guarantor is different please complete guarantor section.
Person Financially Responsible (Guarantor) _____
(last name, first name, middle name)
Mailing Address_____ City_____State_____ Zip Code _____
Home Phone # ( )_____ Soc Sec #_____
Relationship to Patient _____
Employer_____
Mailing Address _____
City_____ State_____
Zip Code _____
Phone # ( )_____ Occupation_____
Emergency Contact (Other than next of kin)
Legal Name _____Primary Phone number_____ Secondary Phone Number_____
(last name, first name, middle name) Relationship to Patient _____

Insurance Information

Primary Insurance_____
Mailing Address _____City_____ State___Zip Code_____
Customer Service/Benefits Phone # ( ) _____ Preauthorization/Hospitalization Phone # ( ) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State _____
Secondary Insurance_____ Mailing Address _____
City_____ State_____ Zip Code_____ Phone # (___) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State _____
Medicare Policy # _____ Effective date _____/_____/_____Retirement date _____/_____/_____
Last Inpatient Hospitalization
Date _____/_____/_____ Hospital name _____
Hospital Mailing Address: _____ City_____State___Zip Code_____
Medicaid Coverage (Please check applicable box) ❑ Medicaid ❑Share Advantage ❑ Primary Care Plus
❑ Out State South Dakota (enter the state) _____
Policy #_____ Effective date _____/_____/_____

Accident/Injury/Work Comp/Information (if applicable)
Date _____/_____/_____ Time _____ State or County Accident Occurred _____

Please mail or fax the completed form to
Business Office
Brookings Health System
300 22nd Ave
Brookings SD, 57006
Phone: 605 696-9000 Fax: 605 696-8889
Thank you for choosing
Brookings Health System for your health care needs.