SHORE MEDICAL CENTER
Somers Point, NJ 08244

ACCESS MANAGEMENT
PRE ADMISSION INFORMATION FORM

Have you previously had services at Shore Medical Center? ☐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 Medical Center 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) _____

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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

Workers Compensation	Auto Accident
Date of Accident: _____	Date of Accident: _____
Where: _____	Where: _____
Name of Employer_____	Name of Insurance Comp: _____
(At time of accident)	Policy Number: _____
Contact Person: _____	Claim Number: _____
Name of Insurance Comp: _____	Adjustor Name: _____
Claim Number: _____	Adjustor Phone: (_____)_____
Adjustor Name: _____	Case Manager: _____
Adjustor Phone: (_____)_____	Case Manager Phone: (_____)_____

Email Address: _____

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

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

The Admissions Office
Shore Medical Center
1 East New York Avenue
Somers Point, NJ 08244

OR fax to 609-926-4716