

PRE-OP SURGICAL QUESTIONNAIRE

GENERAL INFORMATION

Your name: _____
Last Name First Name

By what name should we call you: _____ What is your date of birth? _____

Your current height: _____ Your current weight: _____

Have you had previous operations? (Including C-sections). If YES, list below

Operations	Anaesthetic type, (if known)	Hospital	Anaesthetic Problems?
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		
	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Spinal/epidural		

ALLERGIES

Do you have an allergy to Latex? Yes No Unknown

Do you have allergies and/or intolerances, adverse reactions? (i.e. medication, tape, food, etc.) List below:

Allergy	Reaction

ANAESTHETIC HISTORY

Have you or any blood relatives in your family ever had a bad reaction to anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a family history of Malignant Hyperthermia (high fever) during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain/stiffness in your neck/jaw (TMJ)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain/stiffness in your lower back?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any loose teeth, capped teeth, braces, retainers, or dentures? (please circle appropriate response)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty opening your mouth fully?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had confusion after surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you, or could you be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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HOME MEDICATIONS:

Please list any medications, supplements or herbal preparations that you are currently taking at home.

Medication Name	Dose or Strength	When do you take your medications?					
		A.M.	Noon	P.M.	Bedtime	Other	As Needed

Pharmacy Name and Phone # _____

ADDITIONAL QUESTIONS

Are you taking pain killers regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke or vape any of the following products: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Marijuana Number per day: _____ Number of years: _____ Quit date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol? If yes, how many drinks per week? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or are you currently taking recreational drugs? (eg. marijuana, cocaine, heroin, etc) If yes, when was the last time taken? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No



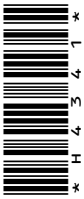
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HEART HEALTH

Do you have or have you had any problems with your heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate if you have any of the follow conditions. Circle all that apply to you.		
Heart attack (MI)	Heart murmur	Chest pain (angina)
Blockages	Stent (Angioplasty)	Valve problems
Peripheral vascular disease	Heart surgery	Irregular heart beat
Heart failure (CHF)	Pacemaker or implanted defibrillator	
Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any recent heart tests in the last 2 years? (Not ECG) (e.g. stress test, holter monitor, echocardiogram)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulty doing either of the following: Walking one (1) block Climbing one flight of stairs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel short of breath when lying flat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had blackouts or fainting spells?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been told you have an aneurysm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you seen a Cardiologist in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiologist's name: _____ Phone Number _____:		

BLOOD HEALTH

Do you have or have you had any problems with your blood or circulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate if you have any of the follow conditions. Circle all that apply to you.		
Sickle cell trait	Sickle cell anemia	Anemia (low blood count)
A blood clot (lungs, legs)	Stroke	Abnormal bleeding
HIV / Aids	Hepatitis	
Have you received blood or blood products in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any personal or religious reasons to decline blood or blood products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If female, how many pregnancies have you experienced?	Number: _____	
Have you seen a Specialist in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Specialist name: _____ Phone Number : _____		



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ENDOCRINE AND METABOLIC HEALTH

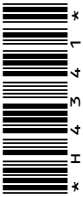
Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how do you manage it? <input type="checkbox"/> Insulin <input type="checkbox"/> Diabetic Pills <input type="checkbox"/> Diet only	
Do you have thyroid problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

RESPIRATORY HEALTH

Do you or have you had any breathing problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Asthma Chronic obstructive pulmonary disease (COPD) Tuberculosis (TB) Tracheostomy	
Do you use oxygen at home to help you breathe?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen a Respirologist in the past 2 years? Respirologist's Name: _____ Phone Number _____:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sleep apnea? (diagnosed by a sleep study)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was a CPAP machine recommended for you? If yes, do you use your CPAP machine? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered no or unknown to having sleep apnea:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you snore loudly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often feel tired, fatigued, or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone observed you stop breathing or choking/gasping during your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have or are being treated for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> N
For Clinic Use only: Gender = male	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age greater than 50 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
	STOPBANG Score:

STOMACH AND INTESTINAL HEALTH

Do you have or have you had any problems with your stomach or intestines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Feeding tube Heartburn or Reflux Hiatus hernia Inflammatory Bowel disease Liver disease (hepatitis, jaundice)	
Do you have difficulty eating or swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any nausea, vomiting, choking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently have an ostomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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KIDNEY AND BLADDER HEALTH

Do you have kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on dialysis? If yes, please circle all that apply: Hemodialysis Peritoneal dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen a Nephrologist in the past 2 years? Nephrologist's name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

NERVE, MUSCLE AND BONE HEALTH

Do you have or have you had any problems with your nerves, muscles or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate if you have any of the follow conditions. Circle all that apply to you.	
Multiple sclerosis Parkinson's disease ALS Stroke or stroke symptoms Brain aneurysm Fibromyalgia Spinal cord problems (stenosis, scoliosis) Seizure disorder (epilepsy) Dementia Migraines Neuropathy Alzheimer's disease Fainting spells (vertigo) in past 2 years Creutzfeldt-Jakob disease (CJD)	
Please indicate if you have any of the follow conditions. Circle all that apply to you.	
Osteoarthritis Anklosing spondylitis Rheumatoid arthritis	
Have you seen a Neurologist or Rheumatologist in the past 2 years? Specialist's name: _____ Phone: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER

Have you had overnight hospitalization within the past year? If yes, please state why: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of mental health issues? If yes, please state: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any ambulatory aids? If yes, please circle all that apply: Wheelchair Walker Cane Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had cancer? If yes, please circle all that apply: Radiation Chemotherapy Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any body piercings?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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<p>Are there any additional health issues/concerns we should be aware of before your surgery?</p> <p>Please list:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I confirm the information provided in this document is accurate to the best of my recollection and abilities.

Signature of Patient

Date

Signature of Substitute Decision Maker (if required)

Substitute Decision Maker Name (Print)

Relationship to Patient



HOSPITAL RATE SCHEDULE – UNINSURED PATIENTS

Effective 1 December 2017

Rates for Uninsured Patients*		
INPATIENT DAILY CHARGES	Standard Ward <small>Acute Care, Rehabilitation, Chronic</small>	\$2,800
	Newborn	\$1,600
	Intensive Care Unit (ICU)	\$4,200 Oakville (OTMH) \$4,200 Milton (MDH)
	Close Observation Unit (COU)	\$3,500 Georgetown (GDH)
	Special Care Nursery (SCN)	\$2,400
OUTPATIENT CHARGES	Emergency Visit	\$700 + \$200 Physician Fee
	Ambulance Fee	\$240
	Outpatient Clinic Visit <small>Rate does not include treatments, drugs, test etc.</small>	\$700
	Specialized Clinics <small>(for example Oncology, Renal Dialysis)</small>	BY QUOTE <small>Contact Finance (accountsreceivable@haltonhealthcare.com or 905-338-4640)</small>

** Hospital charges do not include physician fees which are billed separately*

COST OF SURGERY

By Quote

Contact Finance (accountsreceivable@haltonhealthcare.com or 905-338-4640) to obtain a quotation.

DAILY RATES FOR PREFERRED ACCOMMODATION

Acute Semi-Private	\$250.00	Chronic Semi-Private	\$	45.00
Acute Private	\$290.00	Chronic Private	\$	65.00

COST OF APPLIANCES (e.g., crutches, casts, etc.) and DIAGNOSTIC IMAGING (e.g. Xray, etc) is an additional charge.

PLEASE NOTE:

Prices may change without advance notice.

Hospital charges do not include physician fees which are billed separately



Patient / Family-Recorded Home Medication List

Date Recorded: _____

Pharmacy name and phone number:
Allergies (Describe Reaction): <input type="checkbox"/> No Known Allergies

Currently Taking Medications / Supplements at Home?
 No Unknown

When do you take your medications?

Medication Name	Dose or Strength	A.M.	Noon	P.M.	Bedtime	Other	As Needed



COMPLETED BY: Patient Family Health Care Professional

Patient / Family-Recorded Home Medication List

Why create a Home Medication List?

Your Home Medication List is a tool to help you and your family keep track of all the medications you are taking. It is important to write down everything, including vitamins and supplements, so your healthcare team can provide you with the best possible care. Certain medications might interact with another medication on your list; so, it is important that your Home Medication List be correct and up-to-date.

Instructions for Patient or Family:

1. List **ALL** prescription medications, non-prescription medications, vitamins, herbal and naturopathic products, and/or drug trials.
2. Write the dosage of each medication.
3. For each medication write the number of pills you take at the listed times. See examples.
 - If your medication time is not listed, write the time you take it in the “Other” column
4. If the name of medication is unknown, describe pill under “Medication Name”, and indicate why you are taking it.
5. Your list will be photocopied and put on your hospital file.
6. Always keep a copy of your *Home Medication List* with you.
7. If you stop taking something or start a new medication, be sure to update this list.
8. If you have any questions about your medication or filling out this form, contact your doctor or pharmacist.

EXAMPLES:

Medication Name	Dose or Strength	AM	Noon	PM	Bedtime	Other	As Needed
Metformin	500mg	2		2			
Tylenol Arthritis	650mg					1 at 10:30 am	
Natural Tears	1 drop in left eye						√
Hydrocortisone Cream	0.1% To arm				1		
Vitamin D	1000 units	1					



CHLORHEXIDINE – CHD SHOWER INSTRUCTIONS BEFORE SURGERY

Department of Surgery



Purchase one 4oz (115mL) bottle
Chlorhexidine gluconate 4% (CHD)
from your local pharmacy


DIRECTIONS:

Take **TWO** showers, **one** the **night before surgery** and **another** the **morning of surgery**

1. Remove all jewelry and body piercings.
2. Wash your hair and body using your normal soap and shampoo. Rinse. Step away from the water.
3. Wet a clean washcloth and apply **CHD** solution to the wet washcloth. Use half of the **CHD** for the first shower and half for the next one.
4. Wash your entire body **from the neck down** using the wet, soapy washcloth. Clean your belly button thoroughly with Q-tips and **CHD**, (wash your outer genital and anal areas last). Leave the solution on the skin for **3 minutes**, then rinse the cleaner thoroughly from your body.
5. Use a clean towel to pat your skin dry.
6. Dress in fresh clean sleepwear/clothes. Sleep in clean sheets the night before your surgery.

**If you have any questions or concerns,
contact your surgeon**

 **DO NOT!**

➤ **Do not use** the Chlorhexidine  **near your eyes, ears, mouth or vagina**

➤ **Do not use** if you are allergic to Chlorhexidine; consult your surgeon

➤ **Do not** apply body moisturizing lotion or powder after your shower

➤ **Do not** shave, clip, or wax below your neck for 7 days before surgery

 **IMPORTANT!**

➤ If you experience any **signs of allergy**, for example, a rash, breathing difficulties, palpitations, or swelling of the lips, tongue and throat, or if you feel unwell in any way, **STOP** use and please seek medical advice immediately, visit your Emergency Department, family doctor, or call Telehealth Ontario (1-866-797-0000) or 911

IN-PATIENT SURGERY at Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: _____

Time to Arrive: _____

Please check in at



Surgical Services / Ambulatory Procedures Unit, Level 2 Centre Block

 **Reminder: Bring your package with you to all appointments.**

Instructions for the night before your surgery:

1. Please **DO NOT** have anything to eat or drink after midnight _____.
Remember: no gum, candy or water during fasting time. If indicated, you may have clear fluids (e.g., black tea or coffee, water, apple juice, ginger ale) until 6 hours before your surgery time: _____. Please **DO NOT** drink *orange juice or milk* during this time.
2. Bring all your completed Home Medication list. If requested, also bring all your daily medications.
3. These are the medications to take on the morning of your surgery:

4. Please **DO NOT** smoke the day before and for 2-3 days after your surgery. OTMH is a smoke-free facility.
5. You must remove all make-up, lipstick, nail polish, contact lenses, piercings and jewellery (see note on Page 3 "What Should I Wear").
6. Leave all your jewellery and valuables at home. We cannot be held responsible for lost or stolen items.
7. Please **DO NOT** wear perfume, cologne or other scented personal care products. The Oakville Trafalgar Memorial Hospital is a fragrance-free hospital environment.
8. Remember to bring your eyeglass case and denture cups, if you use these items.

*If you have any questions or concerns, contact the **OTMH Pre-Admission Clinic at 905-338-4497***

What is a Pre-Admission Appointment?

The pre-admission appointment is important to prepare you for surgery. It includes speaking with a Registered Nurse who will arrange any blood tests, x-rays or other tests that may be required. This appointment will take approximately 2 hours. The appointment may be longer if you are required to see the anaesthetist. If you are attending our Wednesday clinic for hip or knee replacement, you should plan to be here for at least 4 hours.

On the day of your pre-admission appointment, you may eat and drink as usual.

Please bring the following with you to your Pre-Admission Clinic visit:

Item	Details
Your Pre-Admission Clinic Package	Given to you by your surgeon.
Pre-Operative Surgical Questionnaire	Completed by you BEFORE your pre-admission visit.
Confidential Admission form	Completed by you BEFORE your pre-admission visit.
Medication List from your pharmacy or your medications in their original containers	
Your Ontario Health card	

What if my health changes before surgery?

If you do not feel well or there is a change in your health before your surgery, please call your surgeon's office as soon as possible. For example, if you have a cold or other illness, discuss this with your surgeon.

What should I do on the day of surgery?

On the day of your surgery, you should report to the Surgical Services/Ambulatory Procedures Unit located on the 2nd floor. Follow the signs provided throughout the hospital.

Please arrive at the time that you have been instructed during your Pre-Admission visit. Be aware that, if you are late, your surgery may be delayed or re-scheduled. Occasionally, the time of your surgery may change. The Pre-Admission Clinic will notify you of any time changes one business day before your surgery.

Important:

The Operating Room may be needed for life threatening emergencies. Although this does not occur often, we do not know in advance when these emergencies are going to occur. If an emergency does happen, the time or date of your surgery may be changed. You will be notified of any changes as soon as possible.

What should I wear?

Please wear loose fitting clothing and flat shoes. We will provide you with a hospital gown. Do not wear make-up, nail polish, contact lenses or any jewellery, including all piercings. If you cannot remove any jewellery/piercings, please have it/them professionally removed prior to your surgery, **due to a risk of surgical burn related to cautery use and potential swelling affecting circulation.** You can wear hearing aids, dentures and glasses, but you will be asked to remove them before surgery. Please bring a hearing aid case, a denture cup and a case for your glasses, if needed.

On the day of your surgery

We will ask you to change into a hospital gown. You will be seen by a nurse who will ask you a few questions and will take your pulse, temperature and blood pressure. The nurse will start an intravenous line in your hand.

Operating Room

We will help you onto the operating table. We will put a blood pressure cuff on your arm, an oxygen monitor on your finger, a heart monitor on your chest and a mask on your face to deliver oxygen. At this time, you will be involved in the briefing portion of the Surgical Safety Checklist. Then, you will be given an anaesthetic.

Post Anaesthetic Care Unit (PACU)

You may be taken to the Post-Anaesthetic Care Unit (sometimes referred to as the Recovery Room) after your surgery. Whether or not you are taken to the PACU depends on the type of anaesthetic you have had. The PACU is a large room and there may be several other patients in the room with you. During your stay in the PACU, you will probably hear the constant beep and whirl of the many machines that are monitoring patients. You may also see and hear a number of nurses and physicians going about their business.

The PACU nurses will measure your pulse, breathing and blood pressure frequently. You will wake up in the PACU. You may have an oxygen mask over your mouth and nose. Your stay in the PACU will be between half (1/2) an hour and two (2) hours, depending on the type of surgery you have had.

After PACU, you will be taken over to your room on the surgical floor where the nurses will monitor your pulse, breathing and blood pressure. The nurses will also get you to do some deep breathing and move your feet and toes.

Visiting Hours

There are no specified visiting hours. However, in our hospitals, quiet time has been designated from the hours of 10:00 p.m. until 7:00 a.m. every day to promote a restful, healing environment for our patients. All Halton Healthcare staff and physicians will work collaboratively with the patient and family member/ partner in care to make adjustments or changes in the care plan to support family presence, bearing in mind the principles of health, safety, privacy, and confidentiality of all patients.

What services are available while I am in the hospital?

- Gift Shop
- Tim Hortons/Starbucks
- Pharmacy
- Bank Machine
- Food Court
- Television, telephone, internet, movies, and games are available for a fee of \$15.00 per day. This fee includes access to available free education and information services. If you want to purchase these services, activation can be done on the touchscreen device beside your bed. Touch the **ACTIVATE SERVICES** icon and follow the onscreen instructions. You can also dial extension **7789** from the bedside device to activate services by phone.

If you want to pre-order these services for your planned hospital stay, there is a toll-free number to call and activate services. The toll-free number is 1-866-223-3686.

Payment for these services is by VISA or MasterCard only.

What should I bring to the hospital on the day of surgery?

You should bring the following items in a small bag labelled with your name.

- Toiletries (e.g., toothbrush, toothpaste, comb, brush, soap, shampoo, shaving kit, etc.)
- Lip and skin moisturizer (the air in the hospital is dry).
- Slippers and housecoat that opens all the way down the front.
- Socks and comfortable shoes with rubber soles (e.g., running shoes).
- Hearing aids, dentures, eyeglasses.
- Any walking aids such as canes or walkers.

Other Suggestions:

- A telephone calling card if you want to make a long distance phone call.
- A small amount of cash to cover the cost of newspapers, coffee, etc.
- Something to read.

Do not bring:

- Valuables such as watches or jewellery.
- Many pieces of identification or credit cards.
- A cellular phone.
- Large pieces of electrical equipment.

PLEASE NOTE: Patients are advised **not** to bring money or valuables into the hospital. The hospital **does not** assume responsibility for patient money or valuables. Patients choosing to bring them into the hospital do so **at their own risk**. It is recognized that patients will have personal items such as clothing, medications and personal support aids with them (e.g., eyeglasses, contact lenses, dentures, hearing aids, mobility aids such as canes, walkers, prostheses or wheelchairs, etc.). However, the hospital **will not** assume responsibility for these items if they are damaged or go missing. **Please mark all items with your name.**

Other Appointments

Date:	_____
Time:	_____
Location:	_____
Date:	_____
Time:	_____
Location:	_____
Date:	_____
Time:	_____
Location:	_____

NOTES:

Accommodation requests will be based on availability at the time of admission.

Have you received any treatment in this hospital before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your name changed since your previous visit? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate previous name: _____
Family Physician	Attending Physician
Allergies	

Patient Information			Partner or Next-of-Kin Information		
Patient Surname		Given Name(s)	Surname		Given Name(s)
Date of Birth	Sex	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-Law	Address		
Address			City	Province	Postal Code
City	Province	Postal Code	Home Phone		Cell Phone
Home Phone		Cell Phone	Work Phone		
Work Phone			Relation to Patient		
Employer Name and Address					
Preferred Language				Religion	
Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Name and Phone Number: _____			

Hospital and Medical Insurances		
Health Card Number (10 digits)	Version Letters on Health Card	Surname and Initials as Shown on the Health Card
Accommodation	Coverage	
<input type="checkbox"/> Ward	<input type="checkbox"/> I do not have insurance coverage. Please bill me directly.	
<input type="checkbox"/> Semi Private	<input type="checkbox"/> I have some coverage. Please bill my insurance company and bill me for any remaining balances	
<input type="checkbox"/> Private	<input type="checkbox"/> I have full coverage. Please bill my insurance company directly	

All self-pay accounts should be paid upon discharge.

Extended Healthcare Benefit Insurance Information and Coverage			
Name of Insurance Company			
Surname and Given Name of Certificate Holder (as registered with insurance company)			Patient Relation to Insurance Holder <input type="checkbox"/> Holder <input type="checkbox"/> Child <input type="checkbox"/> Spouse
Group Policy Number	Identification or Certificate Number	Certificate Holder's Date of Birth	
Employer Name		Employer's Address	

I understand it is my responsibility to verify my insurance coverage.

Signature of Patient: _____ Signature of Registration Clerk: _____ Date: _____