RIDGEVIEW

PATIENT PREREGISTRATION FORM

Prior to your procedure at Ridgeview, please print, complete & return by:
Mail to: 500 South Maple Street, Waconia, MN 55387 -OR- Fax to: 952-442-6524 -OR-
Email to: SDSPreReg@ridgeviewmedical.org If you have questions, call 952-442-8087 and select option 2.

VISIT INFORMATION

What date will you be arriving for your hospital service?

Month _____ Day _____ Year _____

Surgeon/Referring Physician _____

Type of visit _____

Ridgeview place of service:
- ☐ Arlington Campus
- ☐ Le Sueur Campus
- ☐ Waconia Campus
- ☐ Two Twelve Medical Center

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Social Security Number _____ – _____ – _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Widowed ☐ Divorced

Religion _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Patient Refused

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White/Caucasian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Patient Refused

Preferred Language _____

Email _____
(This is required to access your online health record via MyChart)

Patient Address _____

City _____ State _____ Zip Code _____

Phone _____ Mobile Phone _____ Work Phone _____

PATIENT EMPLOYMENT STATUS

☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired *If retired, retirement date:* _____

Employer Name _____ Occupation _____

Employer Phone _____ Employer Address _____

Do you have an Advance Care Directive (Living Will)? ☐ Yes ☐ No

CONTACT INFORMATION

Primary contact name _____

Relationship to patient _____ Birthdate _____

Home phone _____ Cell phone _____ Work phone _____

Secondary contact name _____

Relationship to patient _____ Birthdate _____

Home phone _____ Cell phone _____ Work phone _____

FAMILY PHYSICIAN (name) _____

Clinic name _____ Location _____

CAREGIVER: Individual who will take care of patient at home upon discharge

Name _____ Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Cell phone _____ Work phone _____

INSURANCE INFORMATION

Primary Insurance _____

ID/Policy Number _____ Group/Account Number _____

Do you have Medicare? ☐ Yes ☐ No If yes, please complete the information below.

Medicare ID/Number _____ Effective dates: Part A _____ Part B _____

Are you entitled to Medicare based on: ☐ Age ☐ Disability ☐ End stage renal disease

Do you receive black lung medical benefits? ☐ Yes ☐ No

Will your service be paid by a government program other than Medicare/Medicaid? ☐ Yes ☐ No

Secondary Insurance _____

ID/Policy Number _____ Group/Account Number _____

Work Comp or Auto Insurance Accident Claim Information
(PLEASE complete if this should be billed to a work comp claim or auto claim)

Claim number _____

Type of accident: ☐ Work ☐ Auto ☐ Crime victim ☐ Other

Date of accident _____ Place of accident _____

Body part injured _____ Claims company _____

Claims address _____

Claims agent/adjuster _____ Claim phone number _____