NORTH MISSISSIPPI MEDICAL CENTER
WOMEN'S HOSPITAL
4566 South Eason Blvd. • Tupelo, MS 38801
(662) 377-4800

Pre-Admission Form

(Please print or type)

Today's Date_____ **Expected Delivery Date** _____

Admitting Doctor _____ **Hometown Doctor** _____

Dear Patient,

Thank you for choosing North Mississippi Medical Center's (NMMC) Women's Hospital for your healthcare needs. As a patient at NMMC Women's Hospital, you can expect to receive the finest medical care available anywhere. It is our goal to offer you the same quality service when it comes to matters of business concerning your hospital stay. To speed your admission and minimize the time you spend in Admissions, we ask that you complete and return this Pre-Admission form to the Admission Desk at Women's Hospital after your seventh month of pregnancy. This Pre-Admission form enables our Admission Counselors to prepare in advance the necessary forms for your stay with us. If you need to contact us by phone, please call (662) 377-4921.

Just a note about our visitation policy

Visiting hours are 10 am until 8:30 pm. Siblings may visit the mother, even when the baby is in the room, but no other children under 12 are permitted to visit. Only three adult visitors, including the father, are allowed in the mother's room when the baby is present.

Last Name	First Name	Middle Name	Maiden Name

Date of Birth Mo Day Yr	Race	Age	Sex	Single	Married	Wid.	Div.	Social Security Number	Home Phone	Cell Phone

Mailing Address	City	State	Zip

Patient Employer

Name of Spouse	Spouse Employer	Spouse's Cell Phone

Notify in Case of Emergency (other than spouse)	Relationship	Cell Phone	Home Phone

Patient's Email Address	Church/Religious Preference

HOSPITAL INSURANCE

PLEASE BRING YOUR INSURANCE CARDS / PICTURE ID WITH YOU TO THE HOSPITAL

FOR GROUP INSURANCE, INCLUDING CHAMPUS/TRICARE:

Employer Name		Name of Insured		Insured ID No.

Group No.	Insured SS#	Insured DOB	Name of Insurance Company

FOR SECOND GROUP INSURANCE, INCLUDING CHAMPUS/TRICARE IF APPLICABLE:

Employer Name		Name of Insured		Insured ID No.

Group No.	Insured SS#	Insured DOB	Name of Insurance Company

FOR MEDICARE/MEDICAID:

Name as listed on Medicare/Medicaid card	Number on card

Medicare effective date - Part A	Medicare effective date - Part B

FOR INDIVIDUAL INSURANCE/MEDICARE SUPPLEMENT:

Name of Insurance Company	Name of Insured	Policy No.

Claims Address for Insurance Company	Insured SS#	Insured DOB