300 22nd Ave
Brookings SD, 57006
Phone: 605 696-9000 Fax: 605 696-7758

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
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) ________________

Brookings HEALTH SYSTEM

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 __________________

Brookings HEALTH SYSTEM

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: 605 696-7758
Thank you for choosing
Brookings Health System for your health care needs.

Brookings HEALTH SYSTEM