



WELCOME

**Frederick Memorial
Healthcare System**

400 West Seventh Street
Frederick, MD 21701

We are pleased that you and your physician have chosen Frederick Memorial Hospital and we want to make your stay as pleasant as possible. To speed your admission and to help us plan for your up-coming arrival, please complete and return the attached registration questionnaire form as soon as possible.

The following information is provided to answer some questions you may have. If you have additional questions please contact our Patient Access personnel at (301) 698-3400 from 8am to 6pm Monday through Friday.

Parking

We appreciate your patience during our time of construction to provide a better medical facility to the community. To assist with this situation a courtesy shuttle is available between the hours of 8am-6pm.

Pre-Admission testing (PAT)

You may be asked to complete pre-admission testing prior to your admission. Lab work can be performed at any of our locations:

- Mt. Airy - (301) 829-5802
- Rosehill - (301) 698-3101
- Main Campus - (301) 698-3603

However, to schedule other pre-admission testing please call the Scheduling Center at (301) 698-3400.

At the time of your pre-admission testing, please bring your physician orders and insurance information. You will be asked to complete paperwork and then the required clinical testing will be done. If you have any questions regarding your pre-admission testing, you can call (301) 698-3676.

Admission

If you develop a cold, fever, or other signs of illness within 48 hours of your scheduled admission, please call and inform your physician who will give you further instructions.

Please make every effort to arrive on time for your admission. Most patients are admitted the morning of their surgery and have already completed pre-admission testing.

Patients admitted the day before surgery will complete pre-operative testing.

If you have any questions about the time of your procedure, please contact your physician's office.

What to bring

If you are staying overnight, you may choose to bring your own toothbrush, toothpaste, deodorant, shaving supplies and hair care products. However these can be provided to you once you arrive. Please do not bring any valuables. The hospital cannot be responsible for loss or damage to these items. For your safety, all personally-owned electrical appliances are prohibited. You may want to bring your child's favorite toy or blanket, or your infant's special bottle.

Room accommodations

We do our best to provide the type of room that you request. However, room assignments are based on availability and medical necessity at the time of admission.

No smoking policy

In accordance with state law, no smoking is permitted in any area of Frederick Memorial Hospital.

Financial information

Our Financial Counseling department is available to answer any financial questions you may have. They may be reached at (301) 698-3311 or by dialing 3311 from your room.





Frederick Memorial Healthcare System
400 West Seventh Street Frederick, MD21701

Registration Questionnaire

To expedite your visit, please complete the form and return it as soon as possible.

PATIENT INFORMATION

DUE DATE: / /		BEGINNING DATE OF YOUR LAST MENSTRUAL CYCLE: / /			
REASON FOR ADMISSION or TESTING?					
FAMILY PHYSICIAN:			ADMITTING PHYSICIAN:		
NAME (Last, First Middle):				HOME TELEPHONE #:	
ADDRESS (Street, City, State, Zip):					
DATE OF BIRTH: - -	SOCIAL SECURITY NUMBER: - -	MARITAL STATUS: M S W D	RACE:	GENDER: F M	RELIGION PREF:
EMPLOYER (Street, City, State, Zip):			PHONE: OCCUPATION:		

NEXT OF KIN/PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME:		RELATIONSHIP TO PT:			
ADDRESS (Street, City, State, Zip):					
TELEPHONE #'S: HOME		WORK		OTHER	

Co-pays and deductibles are due at the time services are rendered.
If you need financial assistance, please contact Financial Counseling at (301) 698-3311

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE:		INSURED/POLICY HOLDER:			
INSURANCE ADDRESS:					
PHONE:	POLICY #:		GROUP #:		
INSURED EMPLOYER:			RELATIONSHIP TO PT:		

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE:		INSURED/POLICY HOLDER:			
INSURANCE ADDRESS:					
PHONE:	POLICY #:		GROUP #:		
INSURED EMPLOYER:			RELATIONSHIP TO PT:		

OTHER INSURANCE INFORMATION

NAME OF INSURANCE:		INSURED/POLICY HOLDER:			
INSURANCE ADDRESS:					
PHONE:	POLICY #:		GROUP #:		
INSURED EMPLOYER:			RELATIONSHIP TO PT:		

ADDITIONAL PATIENT INFORMATION

ARE YOU ALLERGIC TO LATEX? Yes No	DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No
RM Preference (if available): Private / Semi-Private	DO YOU HAVE A MEDICAL POWER OF ATTORNEY? Yes No
IS YOUR WEIGHT OVER 300 lbs? Yes No	DO YOU HAVE A LIVING WILL? Yes No