PETERBOROUGH REGIONAL HEALTH CENTRE

Birthing Pre-admission Form

Account #: _____

Return form to: Cashier Office
Peterborough Regional Health Centre, 1 Hospital Drive, Peterborough, ON K9J 7C6
t: 705-876-5026 | f: 705-876-5088

Please complete and return this form at least 10 weeks before your expected date of delivery.
This will help to ensure follow up after discharge.

Expected date of delivery (DD/MM/YYYY): _____ Previous patient at PRHC: ☐ Yes ☐ No

Family Dr. _____ Attending Dr./Midwife: _____

Expected date of discharge from hospital: For vaginal births: 24 hrs. For caesarean births: 48 hrs.

1	Last name:	All given names (no initials) **underline** name used:	Any previous last name and maiden name:	
2	Address:	City:	Postal code:	Religion:
3	Home telephone:	Date of birth (DD/MM/YYYY):	Age:	Marital status:
4	Emergency contact:		Relationship:	
	Telephone:	Address:		
5	Health card # (10 digits)	Version Code	1 or 2 letters following the number or on the bottom right of the card	**Please bring your Health card with you**

****Please select one room preference option listed below ****

Semi Private Room $325 per day **(If I am placed in a private room while requesting a semi-private, the charges for semi-private will be applied)**	
☐ Insurance Coverage	I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much there of as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim.
☐ No Insurance Coverage	I accept financial responsibility of all charges for preferred accommodations.
Private Room $425 per day **(I understand if a private room is not available, I may be placed in a semi-private room with the corresponding rate)**	
☐ Insurance Coverage	I hereby assign to PRHC all of the hospitalization benefits provided by my hospital insurance or so much there of as may serve to satisfy my indebtedness, or that of my dependent to the hospital, and I hereby authorize PRHC to release the information for payment of the hospital claim.
☐ No Insurance Coverage	I accept financial responsibility of all charges for preferred accommodations.
Ward Room	
☐ With valid OHIP Health Card ☐ No OHIP Health Card ☐ WSIB ☐ Out of Province $ 1,307 ☐ Out of Country $ 2,614 *I accept financial responsibility for the basic accommodation charges if not covered by the Ministry of Health or WSIB*	

Insurance Information	**Secondary Insurance**
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of birth (DD/MM/YYYY):	Policy Holder Date of birth (DD/MM/YYYY):
Insurance Company:	Insurance Company:
Certificate / ID Number:	Certificate / ID Number:
Policy/Group Number:	Policy/Group Number:
Name of Employer:	Name of Employer:

I hereby request that assignment of benefits be issued to PRHC.

Print Name: _____ Patient or guarantor accepting financial responsibility

Signature: _____ Witness: _____ Date (DD/MM/YYYY): _____

Note: PRHC does not assume any responsibility for patient valuables.