



CEDARS-SINAI MEDICAL CENTER

- EXECUTIVE MEDICAL SERVICES
- JAPANESE EXECUTIVE MEDICAL SERVICES
- PRIVATE PATIENT

DIVISION OF GENERAL INTERNAL MEDICINE PRE-ADMITTING DATA SHEET

When completed, please
fax this form to Executive
Medical Services at
(310) 423-1929.

NAME OF PRIMARY CARE PHYSICIAN		M.D.		DATE OF APPOINTMENT	
PATIENT		RELIGION	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> Div <input type="checkbox"/> Wid <input type="checkbox"/> Sep	DRIVERS LICENSE NUMBER
NAME OF PATIENT (LAST NAME, FIRST NAME, MIDDLE NAME)		ETHNIC GROUP (RACE)		DATE OF BIRTH (MONTH/DAY/YEAR) / /	TIME OF APPOINTMENT
ADDRESS OF PATIENT (NUMBER, STREET, CITY, STATE, ZIP CODE)				HOME TELEPHONE NUMBER ()	
MAIDEN NAME	MOTHER'S MAIDEN NAME	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (CITY, STATE)	CITIZEN OF WHAT COUNTRY	
OCCUPATION	NAME OF EMPLOYER	ADDRESS OF EMPLOYER	TELEPHONE NUMBER OF EMPLOYER ()		
SPOUSE/NEAREST RELATIVE					
NAME OF SPOUSE OR NEAREST RELATIVE (LAST NAME, FIRST NAME, MIDDLE NAME)			RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER ()	
ADDRESS OF SPOUSE OR NEAREST RELATIVE IF DIFFERENT THAN ABOVE ADDRESS OF PATIENT (NUMBER, STREET, CITY, STATE, ZIP CODE)				BUSINESS TELEPHONE NUMBER ()	
OCCUPATION (SPOUSE ONLY)	NAME OF EMPLOYER (SPOUSE ONLY)	ADDRESS OF EMPLOYER (SPOUSE ONLY)	SOCIAL SECURITY NUMBER (SPOUSE)		
LOCAL RELATIVE OR FRIEND					
NAME OF LOCAL RELATIVE OR FRIEND (LAST NAME, FIRST NAME, MIDDLE NAME)			RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER ()	
ADDRESS OF LOCAL RELATIVE OR FRIEND (NUMBER, STREET, CITY, STATE, ZIP CODE)				BUSINESS TELEPHONE NUMBER ()	
INSURANCE (CHECK APPLICABLE BOXES)			COMMENTS		
<input type="checkbox"/> Group Ins. <input type="checkbox"/> CSMC Employee <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal					
NAME OF INSURANCE COMPANY		SUBSCRIBER NUMBER	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse		
CERTIFICATE NUMBER	GROUP NUMBER	COVERAGE CODE	EFFECTIVE DATE		
IF OTHER - NAME OF INSURANCE					
POLICY NUMBER	GROUP NUMBER	COVERAGE CODE	EFFECTIVE DATE		
MEDICARE NUMBER		MEDI-CAL NUMBER			