niagarahealth
Extraordinary Caring. Every Person. Every Time.

Pre-Registration Form

Surgery Date: _____

Please complete this form entirely and fax to Preoperative Assessment Clinic at the site where the surgery has been booked **7 business days prior** to the Surgery Date. Please ensure all information is legible.

☐ GNG Fax: 905-358-4988 ☐ SCS Fax: 905-323-7564 ☐ WHS Fax: 905-735-8462

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: _____ (Month) _____ (Day) _____ (Year) ☐ Male ☐ Female

Have you used any form of tobacco in the last 6 months? ☐ Yes ☐ No

Address: _____

City: _____ Postal Code: _____

Phone Number: _____ Alternate Number: _____

Marital Status: _____ Church / Religion: _____

Employer: _____

1st Emergency Contact ☐ **Address is the same as above**

Name: _____

Relationship to Patient: _____

Address: _____

City: _____ PC: _____

Phone #: _____ Alt #: _____

2nd Emergency Contact:

Name: _____

Relationship to Patient: _____

Address: _____

City: _____ PC: _____

Phone #: _____ Alt #: _____

Surgeon: (Full First and Last Name)	**Family Doctor: (Full First and Last Name)**	**Family Doctor to receive copies of reports?** ☐ Yes ☐ No

Insurance Information:

Health Card Number: _____ Version Code: _____

Additional Health Insurance Company Name (i.e. Green Shield): _____

Policy / Group Number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

If **WSIB,** Claim Number: _____ Social Insurance Number: _____

Name of Employer at Time of Injury: _____

Room Type Requested: ☐ Ward ☐ Semi-Private ☐ Private

Ontario Health Insurance covers **Ward Accommodation**.
Patients should be aware that companies that provide supplementary insurance may not cover 100% of semi-private / private room charges.
Patients are responsible for knowing information related to their individual coverage.