



CITY OF ALAMEDA HEALTH CARE DISTRICT

ADDRESSOGRAPH
OR
LABEL

Pre-Registration Sheet

(CIRCLE ONE) **Male or Female**

Have you been registered at Alameda Hospital in the past @ CLOSE? Yes / No
(circle one)

Demographics

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Phone Number (____) _____ (CIRCLE ONE) Cell Work Msg

Employer

Patient's Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Employer Phone: (____) _____

Personal

Social Security Number: _____-_____-_____ Date of Birth: ____/____/____

Marital Status: (CIRCLE ONE) Single Married/Partnered Widowed Divorced

Next of Kin

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Cell or Work Phone Number (____) _____

Insurance Information

Company Name: _____ Policy Holder Name: _____

Policy Number: _____ Group Number: _____

Please bring form in or fax to: Alameda Hospital Admitting Department 510-814-4019