Sunnybrook
HEALTH SCIENCES CENTRE

OBSTETRICAL INFORMATION

PAA M5 triage

Ontario Health Card (OHIP) #:____________ Version Code:____________ HFN: ____________

Last Name:____________ First Name: ____________

Other/Previous Name:____________ Birthdate (yy/mm/dd):____________ Religion: ____________

Address:____________

Apt:______ City:____________ Province:____________ Postal Code: ____________

Home Tel. #:____________ Business Tel. #:____________ Ext: ______

Emergency Contact Name:____________ Relationship: ____________

Address:____________ Telephone #: ____________

RESPONSIBILITY FOR PAYMENT:

Complete this section only if the Patient <u>does not have</u> valid OHIP coverage

NOTE: If none of the following situations apply and the patient does not have OHIP they need to contact the Sunnybrook billing department at (416) 480-4157 to confirm billing rates and payment arrangements.

Resident of another province with valid Provincial Health Coverage — Health Card# ____________ Province ____________

Insured by Interim Federal Health — Medavie Blue Cross # ____________

Member of the Canadian Armed Forces — Medavie Blue Cross # ____________

ACCOMMODATION PREFERENCES	DAILY RATES		INITIAL
Private Room	$ 410.00	☐	x______
Semi-Private Room (2 beds)	$ 310.00	☐	x______
Standard Ward (3 or more beds)	$ 0.00	☐	x______
Telephone	$ 4.00	☐	x______

Note: Patients who require ambulance transportation to the Hospital will be charged $45.00 if they have valid OHIP coverage or $240.00 if they do not have valid OHIP coverage x______

Do you have valid supplemental insurance coverage? ☐ YES ☐ NO

Primary Insurance Provider:____________ Name of Policy Holder: ____________

Policy #/Group #:____________ Certificate/ID #: ____________ Employer____________

If for any reason my insurance coverage (including provincial health coverage, if applicable) does not pay for the full cost of care provided, I will be expected to make full payment of any remaining balance

Signature:____________ Date: (yy/mm/dd) ____________

Family Physician:____________ Referring Physician: ____________

Attending Physician:____________ Admission Date: (yy/mm/dd) ____________

☐ CLINIC PATIENT ☐ OFFICE PATIENT