

Please fax the completed form
to 909-596-7306



255 E. Bonita Avenue
Pomona, CA 91767
909-450-0104

MEDICAL ADMISSION INFORMATION

Patient Information

Patient Name _____ Gender: Male Female
DOB _____ SSN _____
Address _____ City _____ Zip _____
Home Phone _____ Alternate/Cell Phone _____
Primary Care Physician _____ Physician Phone _____

Admission Details

Reason for Admission _____

Diagnosis _____

Observation Inpatient

Select level of care: ICU Telemetry Medical/Surgical

Insurance Information

Insurance name _____ Subscriber _____

Insurance ID Number _____ PPO HMO

Secondary Insurance (if applicable)

Insurance name _____ Subscriber _____

Insurance ID Number _____ PPO HMO

Physician Signature _____ Date _____ Time _____

(Casa Colina use only)

Patient accepted Account Number _____

Patient not accepted Reason: No bed available Other _____

Confirmed by _____ Date _____ Time _____