

INPATIENT REGISTRATION AND SUMMARY FORM

Date _____

Community General Hospital

INPATIENT REGISTRATION AND SUMMARY FORM

| | | | | | | | | | | | | | |
|--|--|----------------------------|---|--|---------------------|------------------------------------|------------------------|---------------------------------|----------------------------------|---------------------|------------------------------|--------------|--|
| Patient Account # 12345 | | Medical Record # 215043 | | | | | | | | | | | |
| Patient Name (Last) (First) (Middle) Brown, John | | | Attending Physician Number and Name Jeff T. Moore 97 | | Patient Type Inp | | Hospital Services S | | Admit Date 11/12/99 | | Admit time 11:10 | | |
| Patient Address (Street) (City) (State) (Zip Code) 27 Cottonwood Ln Anytown USA | | | | | | | | Patient Phone # 123-123-4567 | | Date of Prev. Admit | | | |
| Previous or Maiden Name | | | Birth Date 9/10/44 | | Age 54 | | Sex M | | Marital St M | | Religion | | |
| | | | | | | | | | Comments Donor No | | | | |
| Notify in Case of Emergency | | | Address | | | City/State | | | Phone | | | Relationship | |
| Patient Social Security Number 123-45-6789 | | | Employer Name Big Company | | | Employer City/State Anytown, US | | | Guarantor # | | Guarantor Name John Brown | | |
| Guarantor Address Same | | | | | | | | | Guarantor Social Security Number | | | | |
| Payer Southern Company | | | Policy Number 123456789 | | | Insured's Name John Brown | | | Group Name | | | | |
| Financial Class | | | Admitted By AD12 | | | Patient Weight | | | Discharge Date 11/13/99 | | Disch. Time 11:30 | | |
| Provisional Diagnosis Right Ing Hernia | | | | | | | | | | | | | |
| Principal Diagnosis, Secondary Diagnosis and Complications | | | | | | | | | | | | | |
| Principal Procedures and Secondary Procedures | | | | | | | | | | | | | |
| Consultations | | | | | | | | | | | | | |

550.91
214.411-12
Moore53.03
63.3

49520

Disposition of Case

☒ Home☐ Swing Bed☐ Supervised Living☐ Home Health☐ Nursing Home☐ Expired☐ Autopsy☐ AMA☐ Transferred to: _____

Coder

Date

kp

I certify that the narrative description of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

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| Disposition of Case <input checked="" type="checkbox"/> Home <input type="checkbox"/> Swing Bed <input type="checkbox"/> Supervised Living <input type="checkbox"/> Home Health <input type="checkbox"/> Nursing Home <input type="checkbox"/> Expired <input type="checkbox"/> Autopsy <input type="checkbox"/> AMA <input type="checkbox"/> Transferred to: _____ | | | | | | | | Coder kp | | Date | |

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Moore53.03
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49520

Disposition of Case

- ☒ Home
 ☐ Swing Bed
 ☐ Supervised Living
 ☐ Home Health
 ☐ Nursing Home
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 ☐ Autopsy
 ☐ AMA
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| Patient Name (Last) (First) (Middle) Brown, John | | | Attending Physician Number and Name Jeff T. Moore 97 | | Patient Type Inp | | Hospital Services S | | Admit Date 11/12/99 | | Admit time 11:10 | | |
| Patient Address (Street) (City) (State) (Zip Code) 27 Cottonwood Ln Anytown USA | | | | | | | | Patient Phone # 123-123-4567 | | Date of Prev. Admit | | | |
| Previous or Maiden Name | | | Birth Date 9/10/44 | | Age 54 | | Sex M | | Marital St M | | Religion | | |
| | | | | | | | | | Comments Donor No | | | | |
| Notify in Case of Emergency | | | Address | | | City/State | | | Phone | | | Relationship | |
| Patient Social Security Number 123-45-6789 | | | Employer Name Big Company | | | Employer City/State Anytown, US | | | Guarantor # | | Guarantor Name John Brown | | |
| Guarantor Address Same | | | | | | | | | Guarantor Social Security Number | | | | |
| Payer Southern Company | | | Policy Number 123456789 | | | Insured's Name John Brown | | | Group Name | | | | |
| Financial Class | | | Admitted By AD12 | | | Patient Weight | | | Discharge Date 11/13/99 | | Disch. Time 11:30 | | |
| Provisional Diagnosis Right Ing Hernia | | | | | | | | | | | | | |
| Principal Diagnosis, Secondary Diagnosis and Complications | | | | | | | | | | | | | |
| Principal Procedures and Secondary Procedures | | | | | | | | | | | | | |
| Consultations | | | | | | | | | | | | | |

550.91
214.411-12
Moore53.03
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49520

Disposition of Case

- ☒ Home
 ☐ Swing Bed
 ☐ Supervised Living
 ☐ Home Health
 ☐ Nursing Home
- ☐ Expired
 ☐ Autopsy
 ☐ AMA
- ☐ Transferred to: _____

Coder

Date

kp

I certify that the narrative description of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

Attending Physician

Date

Community General Hospital

INPATIENT REGISTRATION AND SUMMARY FORM

| | | | | | | | | | | | | | |
|--|--|----------------------------|---|--|---------------------|------------------------------------|------------------------|---------------------------------|----------------------------------|---------------------|------------------------------|--------------|--|
| Patient Account # 12345 | | Medical Record # 215043 | | | | | | | | | | | |
| Patient Name (Last) (First) (Middle) Brown, John | | | Attending Physician Number and Name Jeff T. Moore 97 | | Patient Type Inp | | Hospital Services S | | Admit Date 11/12/99 | | Admit time 11:10 | | |
| Patient Address (Street) (City) (State) (Zip Code) 27 Cottonwood Ln Anytown USA | | | | | | | | Patient Phone # 123-123-4567 | | Date of Prev. Admit | | | |
| Previous or Maiden Name | | | Birth Date 9/10/44 | | Age 54 | | Sex M | | Marital St M | | Religion | | |
| | | | | | | | | | Comments Donor No | | | | |
| Notify in Case of Emergency | | | Address | | | City/State | | | Phone | | | Relationship | |
| Patient Social Security Number 123-45-6789 | | | Employer Name Big Company | | | Employer City/State Anytown, US | | | Guarantor # | | Guarantor Name John Brown | | |
| Guarantor Address Same | | | | | | | | | Guarantor Social Security Number | | | | |
| Payer Southern Company | | | Policy Number 123456789 | | | Insured's Name John Brown | | | Group Name | | | | |
| Financial Class | | | Admitted By AD12 | | | Patient Weight | | | Discharge Date 11/13/99 | | Disch. Time 11:30 | | |
| Provisional Diagnosis Right Ing Hernia | | | | | | | | | | | | | |
| Principal Diagnosis, Secondary Diagnosis and Complications | | | | | | | | | | | | | |
| Principal Procedures and Secondary Procedures | | | | | | | | | | | | | |
| Consultations | | | | | | | | | | | | | |

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Disposition of Case

☒ Home☐ Swing Bed☐ Supervised Living☐ Home Health☐ Nursing Home☐ Expired☐ Autopsy☐ AMA☐ Transferred to: _____

Coder

Date

kp

I certify that the narrative description of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

Attending Physician

Date