

ADMISSION FORM

Please print legibly – fill in all spaces

**A. PATIENT DATA**

Patient's name (last, First, Middle)	Patient's SSN	Date of Birth (dd/mmm/yy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:	Phone Number Work _____ Home _____	Health Record Home Location Yokosuka Negishi Atsugi Zama Sasebo Yokota Iwakuni Misawa Other _____	
Patient category: <input type="checkbox"/> Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> Spouse <input type="checkbox"/> Child (# ) <input type="checkbox"/> Dod/Civ <input type="checkbox"/> Other( )			
Marital Statuses: <input type="checkbox"/> Single <input type="checkbox"/> Married		Religious Preference:	
Ethnic Status: <input type="checkbox"/> Hisp <input type="checkbox"/> SE Asian <input type="checkbox"/> Filipino <input type="checkbox"/> Asian/Pacific Island <input type="checkbox"/> Other			
Race: <input type="checkbox"/> Cauc <input type="checkbox"/> Afr amer <input type="checkbox"/> Asain <input type="checkbox"/> Native North American (Indian) <input type="checkbox"/> Other			
Check as appropriate: <b>MUST BE COMPLETED ON ALL ADMISSIONS &amp; PRE-ADMISSIONS</b>			
Do you have: <input type="checkbox"/> Power of attorney <input type="checkbox"/> Living will <input type="checkbox"/> Both <input type="checkbox"/> Neither			
If neither, Patient must be provided information on Advance Directives <b>All patients/ NOK must initial the receipt of adv. Dir.</b> _____			

**B. Sponsor Data**

Sponsor's name (Last, First, Middle)	Sponsor SSN	Date Of Birth (dd/mmm/yy)
Service: <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Dod/ Civ <input type="checkbox"/> State Dept <input type="checkbox"/> Merchant Marine <input type="checkbox"/> Other		

Duty Address	Rank:
	Rate/Designator/AFSC:
UIC:                      Duty Phone:	Length of Service      Years:
	Flying Status: <input type="checkbox"/> Yes <input type="checkbox"/> No

**C. Emergency Data:**

Name (Last, First, Middle)	Relationship:
Address	Phone number:

**D Next of Kin**

Name (Last, First, Middle)	Relationship:
Address	Phone number:

**E. Medical Officer Completes This Box**

Admission Diagnosis:	Admission Date		
Medical Officer Signature:	EST PRD HOSP	Clinical service	Ward
			<input type="checkbox"/> 5B <input type="checkbox"/> Icu med <input type="checkbox"/> 3Aob <input type="checkbox"/> Icu surg <input type="checkbox"/> Nursery