Pre-Admission Form (Please print and complete in full)

The BirthPlace
SANTA MONICA

Your OB physician's name ____________ Pediatrician's name ____________

Your primary care physician's name ____________

Estimated date of delivery ____________ Have you been a patient at this hospital before? ☐ Yes ☐ No

If yes, when ____________ Under what name(s)? ____________

Patient Information

Name ____________ Birthdate ____________

Religious preference ____________ Birthplace ____________

Last 4 digits of social security number ____________ CA Driver's License or ID ____________

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

Ethnic background: ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other

Maiden name ____________ Mother's maiden name ____________

Street address /Apt. ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Patient Employment Information

Occupation ____________ Employer name ____________

Employer street address ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Spousal Information

Name ____________ Birthdate ____________

Last 4 digits of social security number ____________

Ethnic background: ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other

Occupation ____________ Employer name ____________

Employer street address ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Insurance Subscriber / Responsible Person (Policy Holder)

Name ____________ Relationship to patient ____________

Street address ____________ Apt. ____________

City ____________ State ____________ Zip ____________

Telephone ____________ Birthdate ____________

Occupation ____________ Employer name ____________

Last 4 digits of social security number ____________ Other ID ____________

Employer street address ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Notify in Emergency / Next of Kin

Name ____________ Relationship to patient ____________

Street address ____________ Apt. ____________

City ____________ State ____________ Zip ____________

Telephone (Day) ____________ (Evening) ____________

Insurance Information

Name of insurance company or administrator ____________

Employer street address ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Name of insured person ____________ Relationship to patient ____________

Social security number ____________ Policy Group No. ____________

Is an authorization for treatment required by your health plan? ☐ Yes ☐ No

Effective date ____________ Annual deductible ____________ % Coverage ____________

Secondary insurance company or administrator, if any ____________

Employer street address ____________ City ____________

State ____________ Zip ____________ Telephone ____________

Name of insured person ____________ Relationship to patient ____________

Social security number ____________ Policy Group No. ____________

Is an authorization for treatment required by your health plan? ☐ Yes ☐ No

Effective date ____________ Annual deductible ____________ % Coverage ____________

For MediCal beneficiaries, the following is required:

- Medi-Cal ID # ____________
- A copy of your current card; and
- Photo identification

For Medicare beneficiaries, the following is required:

- Medicare number ____________
- A copy of your Medicare card

I certify that the above information is correct and accurate to the best of my knowledge.

____

Patient signature or patient representative signature Date