Pre-Admission Registration

The BirthPlace offers pre-admission registration so that the joy of your special moment is not tempered by the stress of last-minute details. We encourage you to complete and return this Pre-Admission form as soon as possible during your pregnancy. Additionally, please read and sign the Condition of Services forms — one for you and one for your baby. Complete the other steps noted in the Pre-Admission Checklist on the next page.

Once we receive your completed forms, we will finish the pre-admission process by entering your information into our computer system and contacting your insurance company for verification. We will send an acknowledgment after receiving your forms.

When your doctor's office instructs you to come to our hospital after labor begins, please go directly to our labor and delivery unit. Remember to bring your insurance card with you.

Pre-Admission Checklist

To complete the pre-admission process for The BirthPlace, please follow all of the steps listed below:

1. Complete the attached Pre-Admission Registration form. If you have not yet selected a pediatrician for your baby, please note "TBD" (to be decided) in the space after "Pediatrician."

2. Complete two Terms and Conditions of Service forms — one for you and one for your baby — and sign them. (If you're expecting multiples, you must complete a form for each baby. Call hospital admissions for extra forms. Keep the yellow copy for your records.)

3. Before completing the section on "Advanced Directives" in the Terms and Conditions of Service forms, read the enclosed pamphlet "Making an advanced directive." This will help you better understand and answer the two questions regarding advanced directives.

4. Do NOT answer the "Advanced Directives" questions on your baby's form. Draw a line through them and note "Minor."

5. Submit all of the above documents with your insurance form or a copy of your insurance card (both sides).

6. If you have a completed an advance directive form, please enclose a copy with these forms.

**For the actual advance directive form, please call hospital admissions. For Ronald Reagan UCLA Medical Center, call 310-267-8000 and select option 3. For UCLA Medical Center, Santa Monica, call 424-259-6727.*

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

Your OB provider's name _____ Pediatrician's name _____

Your primary-care physician's name _____ Telephone (____) ____ - _____

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

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

Expected births: ☐ 1 ☐ 2 ☐ Other Scheduled for OB Tour: ☐ Yes ☐ No Date __ __ /__ __ /__ __ __ __

Patient Information

Name _____ Birthdate __ __ /__ __ /__ __ __ __

Religious preference _____ Birthplace _____

Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Life Partner
☐ Reg Domestic Partner ☐ Significant Other

Ethnic background: ☐ Alaska Native ☐ American Indian ☐ Asian: (please circle) Asian Indian, Chinese, Filipino, Indonesian, Japanese, Korean, Pakistani, Taiwanese, Thai, Vietnamese, Other ☐ African American
☐ Pacific Islander: (please circle) Guamanian or Chamorro, Native Hawaiian, Samoan, Other
☐ Caucasian ☐ Unknown ☐ Declined to Specify

Maiden name _____ Mother's maiden name _____

Street address /Apt. _____ City _____

State _____ Zip _____ Telephone (_____) _____ - _____

E-mail address _____

Patient Employment Information

Occupation _____ Employer name _____

Employer street address _____ City _____

State _____ Zip _____ Telephone (_____) _____ - _____

Spouse / Life Partner / Reg Domestic Partner / Significant Other Information

Name _____ Birthdate __ __ /__ __ /__ __ __ __

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 _____

Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Other ID _____

Employer street address _____ City _____

State _____ Zip _____ Telephone (_____) _____ - _____

The BirthPlace

Admission Office contact numbers:
Santa Monica 424-259-6727 / **Westwood** 310-267-8000 Option#3

Notify in Emergency / Next of Kin

Name _____ Relationship to patient _____

Street address _____ Apt. _____

City _____ State _____ Zip _____

Home telephone (_____) _____ - _____ Cell (_____) _____ - _____ Work (_____) _____ - _____

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

Member ID _____ Effective date __ __ /__ __ /__ __ __ __

Newborn coverage plan _____ Covers ☐ Mother ☐ Father ☐ Baby

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

Member ID _____ Effective date _____

Newborn coverage plan _____ Covers ☐ Mother ☐ Father ☐ Baby

For Medi-Cal beneficiaries, the following is required:

- Medi-Cal ID # _____
- A copy of your current card
- 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