MATERNITY PRE-ADMISSION QUESTIONNAIRE

Adventist Health Simi Valley

PLEASE COMPLETE THIS FORM AND RETURN ITTO THE ADMITTING DEPARTMENT ONE MONTH PRIOR TO YOUR DUE DATE. PLEASE REMEMBER TO BRING YOUR INSURANCE CARD WITH YOU. **PLEASE PRINT ALL INFORMATION CLEARLY**

TO BE COMPLETED BY PATIENT
ESTIMATED DUE DATE
YOUR PHYSICIAN
YOUR PEDIATRICIAN

PATIENT DATA

PATIENT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE (MO/DAY/YR)	RELIGION		
SOCIAL SECURITY NUMBER — —	RACE ☐ WHITE ☐ AFRICAN AMERICAN ☐ OTHER ☐ ASIAN ☐ HISPANIC	MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	PREVIOUSLY A PATIENT HERE? ☐ YES ☐ NO	IF YES, UNDER WHAT NAME?	
PATIENT'S HOME ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE NUMBER ( )	
NOTIFY IN CASE OF EMERGENCY	RELATIONSHIP	ADDRESS, CITY, STATE	ZIP CODE	TELEPHONE NUMBER ( )	
PATIENT'S EMPLOYER	PATIENT'S OCCUPATION	ADDRESS, CITY, STATE	ZIP CODE	TELEPHONE NUMBER ( )	
SPOUSE'S NAME	SPOUSE'S BIRTHDATE (MO/DAY/YR)	SPOUSE'S EMPLOYER	SPOUSE'S SOCIAL SECURITY NUMBER — —		
SPOUSE'S EMPLOYER'S ADDRESS, CITY, STATE	ZIP	EMPLOYER'S TELEPHONE NUMBER ( )	SPOUSE'S OCCUPATION		
RESPONSIBLE PARTY, IF NOT THE ABOVE	BIRTHDATE	EMPLOYER	SOCIAL SECURITY NUMBER — —		
EMPLOYER'S ADDRESS	CITY, STATE	ZIP	EMPLOYER'S TEL	OCCUPATION	

FINANCE

PLEASE BE PREPARED TO PAY ANY CO-PAYS OR DEDUCTIBLES UPON ADMISSION

FINANCE

INSURANCE ONE

NAME OF INSURED	GROUP POLICY HOLDER (EMPLOYER, ASSOC., ETC.)	PATIENT'S RELATIONSHIP
NAME OF INSURANCE COMPANY	ADDRESS	TELEPHONE NUMBER ( )
SOCIAL SECURITY NUMBER — —	GROUP NUMBER	POLICY NUMBER

INSURANCE TWO

NAME OF INSURED	GROUP POLICY HOLDER (EMPLOYER, ASSOC., ETC.)	PATIENT'S RELATIONSHIP
NAME OF INSURANCE COMPANY	ADDRESS	TELEPHONE NUMBER ( )
SOCIAL SECURITY NUMBER — —	GROUP NUMBER	POLICY NUMBER

DOES INSURANCE COVER HOSPITAL NURSERY CHARGES? ☐ YES ☐ NO

IF INSURANCE IS PAID WITH AN HMO, PLEASE FURNISH THE FOLLOWING:

NAME OF PRIMARY CARE PHYSICIAN
NAME OF CLINIC

COMMENTS