

Saint John's Maternity Pre-Admission Form

Your Physician's Name

Is this a scheduled cesarean section? Yes No

Estimated Date of Admission or Due Date	Last Menstrual Period
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Have you been a patient at Saint John's before? Yes No

When?	Under What Name?
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Have you completed a Durable Power of Attorney for Health Care? Yes No

PATIENT INFORMATION

Legal Last Name	First Name	MI	Date of Birth
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Marital Status Married Single Divorced Widowed Separated

Street Address	City	State	Zip Code
Telephone 1	Telephone 2	Email	
Social Security Number	Driver's License or ID Number	Mother's Maiden Name	
Religion/Religious Preference	State or Country of Birth		

PATIENT EMPLOYMENT INFORMATION

Employer Name	Street Address	City	
State	Zip Code	Telephone	Occupation

SPOUSE / SIGNIFICANT OTHER INFORMATION

Name	Street Address	City		
State	Zip Code	Telephone 1	Telephone 2	Relationship to Patient

EMERGENCY CONTACT

Name	Street Address	City		
State	Zip Code	Telephone 1	Telephone 2	Relationship to Patient

INSURANCE POLICY HOLDER

Name	Date of Birth	Relationship to Patient	Driver's License or ID Number		
Billing Street Address	City	State	Zip Code	Telephone	
Employer Name	Employer Address	City	State	Zip Code	
Employer Telephone	Occupation	Social Security Number			

PRIMARY INSURANCE

Name of Insurance Company or Administrator					
Claims Street Address	City	State	Zip Code	Telephone	
Policy Number	Group Number	Insured's Relationship to Patient			

Do you have a: HMO PPO

SECONDARY INSURANCE

Name of Insurance Company or Administrator					
Claims Street Address	City	State	Zip Code	Telephone	
Policy Number	Group Number	Social Security Number	Date of Birth		

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

Patient signature _____ Date _____

Patient representative signature _____ Date _____

Please mail or fax completed form, a copy of a picture ID and copies of insurance cards (front and back) to:

Saint John's Health Center Admitting Office
1328 Twenty Second Street • Santa Monica, CA 90404 • FAX (310) 449-5230

For verification of registration or questions, call (310) 829-8358

Note: The uninsured portion of your account is due prior to discharge (deductible, co-pay and co-insurance). Any questions regarding payment should be directed to the Financial Counseling Department at (310) 829-8376.

Federal law requires the Health Center to ask all patients if they have completed an **Advanced Directive Form** and to provide information about their rights to make health care decisions. If you have completed an **Advanced Directive Form**, please bring a copy when you are admitted to the hospital.