SAN ANTONIO REGIONAL HOSPITAL

Maternity Pre-Admission Form

Mail completed form to: Maternity Pre-Admission
999 San Bernardino Road, Upland, CA 91786
Or place in the drop box in the main lobby of the hospital.

This form contains information to begin your medical record and to verify your insurance. please complete the form and return it by mail or fax (909.694.1080) to the Hospital Admitting Department as soon as possible, prior to your scheduled arrival date. If possible, please attach a copy of your insurance card to the form.

Please complete the form and return it to the Hospital Admitting Department prior to your fifth month of pregnancy.

Patient Information (Please Print)

DOCTOR'S NAME	PRIMARY CARE PHYSICIAN		MEDICAL GROUP						
EXPECTED DELIVERY DATE	PEDIATRICIAN NAME		MARITAL STATUS	M	S	W	D	SEP	LIFE PARTNER
LAST NAME	FIRST NAME	MIDDLE NAME	EMAIL ADDRESS						
STREET ADDRESS		CITY	STATE	ZIP					
DATE OF BIRTH	HOME PHONE	CELL PHONE	MAIDEN NAME						
SOCIAL SECURITY NUMBER	BIRTH PLACE (STATE)	RACE / ETHNIC GROUP	RELIGION						
EMPLOYER	ADDRESS								
CITY	STATE	ZIP	PHONE & EXTENSION						
HAVE YOU BEEN A PATIENT AT THIS HOSPITAL? YES ☐ NO ☐	DRIVER'S LICENSE #	OCCUPATION/EMPLOYER							

Insurance Information (Please Print)

DO YOU HAVE INSURANCE FOR THIS HOSPITALIZATION? YES ☐ NO ☐ IF NO, PLEASE CALL 909.920.4826.

SUBSCRIBER NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU	DATE OF BIRTH
PRIMARY INSURANCE	GROUP NUMBER	SECONDARY INSURANCE / SUBSCRIBER	GROUP NUMBER
EMPLOYER	MEMBER NUMBER	EMPLOYER	MEMBER NUMBER
ADDRESS / CITY / STATE / ZIP		ADDRESS / CITY / STATE / ZIP	DATE OF BIRTH
INS BILLING ADDRESS / CITY / STATE / ZIP	PHONE NUMBER	INS BILLING ADDRESS / CITY / STATE / ZIP	PHONE NUMBER

INSURANCE BILLING IS HANDLED AS A COURTESY TO THE PATIENT.

SAN ANTONIO REGIONAL HOSPITAL

Maternity Pre-Admission Form

Emergency Contacts / Family Spokesperson / Additional Information (Please Print)

EMERGENCY CONTACT NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
FAMILY SPOKESPERSON NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		
ALTERNATE DECISION MAKER NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		
ALTERNATE EMERGENCY CONTACT NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		

PLEASE BRING INSURANCE CARD(S) AND CLAIM FORMS.

MAY WE GIVE CAIR (CALIFORNIA IMMUNIZATION REGISTRY) PERMISSION TO SHARE YOUR/YOUR CHILD'S IMMUNIZATION INFORAMTION WITH YOUR PHYSICIAN AND/OR SCHOOL FOR YOUR CONVENIENCE? YES ☐ NO ☐

DO YOU HAVE ANY ALLERGIES? YES ☐ NO ☐ DO YOU HAVE AN ADVANCE DIRECTIVE? YES ☐ NO ☐
(IF YES, PLEASE BRING A COPY TO THE HOSPITAL)

4MYHEALTH - SAN ANTONIO REGIONAL HOSPITAL OFFERS A SECURE, ONLINE SITE THAT ALLOWS YOU EASY ACCESS TO YOUR ELECTRONIC HEALTH INFORMATION. IF YOU WOULD LIKE TO ACCESS YOUR ELECTRONIC HEALTH INFORMATION IN THIS MANNER, PLEASE COMPLETE THE FOLLOWING:
EMAIL ADDRESS:

PASSWORD (SELECT ONE)	LAST 4 DIGITS OF YOUR SOCIAL SECURITY NUMBER	ANSWER:
	YEAR YOU GOT MARRIED	
	YEAR YOU GRADUATED	
	BIRTH YEAR	

VALUABLES: JEWELRY, ELECTRONIC DEVICES, MONEY IN LARGE AMOUNTS, OR OTHER VALUABLES SHOULD NOT BE BROUGHT TO THE HOSPITAL.

I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY OR OTHER THIRD PARTY PAYORS.

DATE SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS A MINOR)

THANK YOU FOR CHOOSING SAN ANTONIO REGIONAL HOSPITAL.