Antelope Valley Medical Center

Obstetrics Pre-Admission Information Form

1600 West Ave J Lancaster, CA 93534
661-949-5000

Completed by Admitting:
Email Y / N

GENERAL OBSTETRIC INFORMATION

Date form completed_____

Attending Physician:_____ **Pediatrician for Newborn**:_____

Due Date:_____ Date of last menstrual period:_____

Did you receive your prenatal care at one of the following clinics? No___ Yes____ (If yes, please check below)

_____ Kaiser _____ HDHS/Ave I Clinic _____ AV OB Clinic _____ Bartz AltaDonna

If other where? _____

PATIENT INFORMATION

Last Name: _____ **First Name**: _____**Middle Initial**: _____

Maiden Name: _____ **AKA**_____ **Mother's Maiden Name**: _____
(other names you are known as)

Address: _____**City**:_____**State**:_____**Zip**: _____

Home Phone: _____ **Cell Phone**: _____

Social Security # or Individual Tax ID #:_____ **Date of Birth**: _____ **Driver's License #**: _____

Marital Status: (circle one) Single Married Separated Divorced Widow State Registered Domestic Partner

Employer: _____ **Employer's Phone**: _____ **Occupation**: _____

Employer's Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Employment Status: (circle one) full time part time **Email Address:** _____

Religion: _____ **Do you have an Advance Directive?** (circle one) Yes No If yes, where on file:_____

Race: (circle one) Caucasian Black Asian American Indian Other: _____

Ethnicity: (circle one) Hispanic Non-Hispanic Unknown Specific Background: _____

EMERGENCY CONTACT INFORMATION

Spouse Name: _____ **Date of Birth**: _____ **Occupation**: _____
Last First

Employer: _____ **Home/Cell**: _____ **Work Phone**: _____

Employer Address: _____**City**: _____ **State**: _____ **Zip**: _____

Next of Kin Name: _____

Relationship: _____ **Home/Cell**: _____ **Work Phone**: _____

Alternate contact name: _____

Relationship: _____ **Home/Cell**: _____ **Work phone**: _____

Please complete reverse side of form. Thank you!

PRIMARY INSURANCE

Insurance Name: _____**ID #**: _____**Group #**: _____

Medical Group: _____ **Primary Care Physician**: _____

Insured's Name: _____ **Relationship to you:** (circle one) self spouse step child natural child foster child other

SECONDARY INSURANCE

Insurance Name: _____ **ID #**: _____ **Group #**: _____

Medical Group: _____ **Primary Care Physician**: _____

Insured's Name: _____ **Relationship to you:** (circle one) self spouse step child natural child foster child other

Once this form is completed, you will be asked to provide your insurance card so we will be able to make copies. Please contact us with any changes (address, phone number, insurance or physician) prior to your delivery. It may be necessary to have you sign new paperwork if a change is made. The WIP Admitting Department can be reached at 661-949-5410.

BIRTH CERTIFICATE INFORMATION FOR NEWBORN BABY

The following information is needed to complete your baby's Birth Certificate. If the information is not available at the time you complete this form, please bring the information with you when you deliver. If you are NOT LEGALLY MARRIED and wish to establish paternity this information is <u>required</u>.

Father/Parent of Infant Information:

Legal Name of Father: _____
First Middle Last

Home Address: _____ **City**: _____ **State**: _____ **Zip**: _____

State/Country of Birth: _____ **Phone**: _____ **Date of Birth**: _____

Social Security # or Individual Tax ID #: _____ **Email Address**: _____

Race: (circle one) Caucasian Black Asian American Indian Other: _____

Ethnicity: (circle one) Hispanic Non-Hispanic Unknown Specific Background: _____

Usual Occupation –Title: _____

Type of Business/Industry: _____

Years of Education Completed: _____.

If you have questions about the BIRTH CERTIFICATE, please contact Birth Certificates at (661) 949-5019.