

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/Avenue I Clinic _____ AV OB Clinic _____ Bartz AltaDonna

_____ Palmdale Women's Health If other, where? _____

Are you a Surrogate for this pregnancy? No _____ Yes _____

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 _____ Email Address: _____

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

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: _____

Patient's Employer: _____ Employer's Phone: _____ Occupation: _____

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

Employment Status: (circle one) full time part time

EMERGENCY CONTACT INFORMATION

 Spouse/Partner Name: _____ Date of Birth: _____ Home/Cell: _____
 Last _____ First _____

Employer: _____ Occupation: _____ Work Phone: _____

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

Emergency Contact Name: _____

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

Emergency 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 required.

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.