

## **Obstetrics Pre-Admission Information Form**

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

GENERAL OBSTETRIC INFORMATION		Date form completed				
Attending Physician:		Pediatrician for Newborn:				
Due Date:	Date of last menstrual period:		-			
Did you receive your prenat	al care at one of the following clinics?	No	Yes	(If yes, please chec	k below)	
Ave K-6 OB ClinicKaiser		linic		High Desert Medical Group Clinic		
AV Hospital Clin	nic LancasterAV Hos	AV Hospital OB Clinic – Palmdale		If other where?		
PATIENT INFORMAT	ΓΙΟΝ					
Last Name	First na	_First name		Middle Initial		
Maiden Name:	Mother's Maiden Name			AKA(other names you are known as)		
	City					
Home Phone:	Message Phone		(	Cell #		
Social Security Number:	Date of Birth			Drivers License #		
Marital Status: (circle one)	Single Married Separated D	ivorced	Widow			
Patient's Employer	Emplo	Employers Phone#		Occupation		
Employers Address	City			State	Zip	
Employment Status: (circle one)	full time part time					
Religion:	Do you have an Advance Direc	tive? (circle	one) Yes No	If yes where on file		
Race: (circle one) Caucasian	Black Asian American	Indian O	ther:			
Ethnicity: (circle one) Hispan	nic Non-Hispanic Unknown					
EMERGENCY CONTA	ACT INFORMATION					
Spouse Name:Last	First	Date	of birth	Occupation		
Employer:	Employer Address:		City	State	Zip	
Next of Kin Name:	Relationship		_Home/Cell#	Work Phone#		
Alternate contact name:	Relationship		Home/Cell #	Work p	Work phone#	

## **GUARANTOR INFORMATION** (Person responsible for the balance not paid by insurance) Relationship Date of Birth Drivers License # Last First City State Zip Home Address Social Security Number Employer **Employers** City State Zip Address Home phone#\_\_\_\_\_\_\_Work Phone#\_\_\_\_\_ PRIMARY INSURANCE Insurance Name Medical Group\_\_\_\_\_Primary Care Physcian\_\_\_\_\_ Insured's Name\_\_\_\_\_\_\_Relationship to you: (circle one) self spouse step child natural child foster child other SECONDARY INSURANCE Insurance Name Primary Care Physician\_\_\_\_\_ Medical Group \_\_\_\_\_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. We will make copies of your card and ask you to sign all of your admission paperwork. Please contact us with any changes (address, telephone number, insurance or physician) prior to your delivery. It may be necessary to have you sign new paperwork if a change is made. The Admitting Department can be reached 6(61) 949-5411. 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. **Father of infant information:** Legal Name of Father First Middle Last State/Country of Birth: \_\_\_\_\_\_ Date of birth: \_\_\_\_\_ Social Security#\_\_\_\_\_

If you have questions about the BIRTH CERTIFICATE, please contact the Medical Records Department at (661) 949-5019.

Usual Occupation – Title \_\_\_\_\_\_ Type of Business or Industry \_\_\_\_\_

Years of Education Completed (Do not include trade school)