Antelope Valley Medical Center

OB/ GYN Outpatient Clinic

Pre-Admission Information Form

44105 15TH Street West Suite 301, Lancaster CA 93534 / Phone: 661-726-6180

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)

_____HDHS/Ave I Clinic _____Kaiser Clinic _____Bartz AltaDonna Clinic

_____AVMC OB Clinic If other where?_____

PATIENT INFORMATION

Last Name_____First name_____Middle Initial_____

Maiden Name:_____Mother's Maiden Name_____AKA_____
(other names you are known as)

Address:_____City_____State:_____Zip_____

Home Phone:_____Message Phone_____Cell #_____

Social Security Number:_____Date of Birth_____Drivers License #_____

Marital Status: (circle one) Single Married Separated Divorced Widow

Patient's Employer_____Employers Phone#_____Occupation_____

Employers Address_____City_____State_____Zip_____

Employment Status: (circle one) full time part time Smoker: Yes_____No_____

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

EMERGENCY CONTACT INFORMATION

Spouse Name:_____Date of birth_____Occupation_____
Last First

Employer:_____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!

GUARANTOR INFORMATION (Person responsible for the balance not paid by insurance)

Name_____Relationship_____Date of Birth_____Drivers License #_____
Last First

Home Address_____City_____State_____Zip_____

Social Security Number_____Employer_____

Employers Address_____City_____State_____Zip_____

Home phone#_____Cell phone#_____Work Phone#_____

PRIMARY INSURANCE

Insurance Name_____ID#_____Group #_____

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_____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. 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 at 661-949-5411.

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#**_____

Usual Occupation –Title_____**Type of Business or Industry**_____

Years of Education Completed (Do not include trade school)_____.

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