Form updated 10/2022

POMONA VALLEY HOSPITAL MEDICAL CENTER

CONFIDENTIAL

Labor & Delivery OB Pre-Registration Form

Please Print Legibly

Welcome to Pomona Valley Hospital Medical Center. Your registration form will be processed no earlier than two months prior to your due date. Please make sure you check the correct boxes. Thank you and we look forward to serving you for your maternity stay.

Due Date: _____ First day of last menstrual period: _____

Obstetrician (OB): _____ Pediatrician (PEDS): _____

I am expecting a: ☐ Vaginal delivery Primary Care MD_____

☐ Cesarean section **Are you a surrogate**: ☐ Yes ☐ No

Have you ever been a patient at Pomona Valley Hospital Medical Center? ☐ Yes ☐ No

If yes, date of most recent visit: _____

LEGAL NAME

Last Name: _____ First Name: _____

Middle Initial: ____

Name used at prior visit (if different): _____

Other Names Used/Maiden Name: _____

Patient's Social Security #:_____

Birthdate: _____ Birthplace: _____

Email Address: _____

Home Address (do not use P.O. Box #):_____

City: _____State: _____ Zip:_____

Primary Contact Phone #: ( )_____ ☐ Home ☐ Work ☐ Cell

Race:_____Ethnicity: ☐ Hispanic ☐ Other _____

Organ Donor: ☐ Yes ☐ No

Legal Marital Status: ☐ Married ☐ Single

☐ Registered Domestic Partner

☐ Legally Separated ☐ Divorced ☐ Other:_____

Primary language: _____ Religion: _____ Occupation: _____

Patient's Employer:_____ Address: _____

City: _____State: _____Zip: _____

Employer Phone #: ( )_____

Work Status: ☐ Full Time ☐ Part Time

Person to Notify/Emergency Contact Name:_____

Relationship: _____

Primary Contact Phone #: ( )_____ ☐ Home ☐ Work ☐ Ce

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METHOD OF PAYMENT: ☐ Self-Pay ☐ Primary Insurance ☐ Secondary Insurance

PRIMARY INSURANCE PLAN: _____

Insurance Phone #: ( )_____ ☐ HMO ☐ MediCal ☐ PPO ☐ Other: _____

Authorization #: _____ Expiration Date: _____

If insurance is HMO-Medical Group: ☐ Alpha Care ☐ Healthcare Partners ☐ Primecare Chino Valley

☐ ProMed Pomona Valley ☐ Other: _____

Subscriber's Name: _____

Birthdate: _____ Gender: _____

Relationship to Patient:_____

Policy ID#: _____Group #: _____

Subscriber's Home Address: _____

Phone #: ( ) _____

SECONDARY INSURANCE PLAN: _____

Insurance Phone #: ( ) _____ ☐ HMO ☐ MediCal ☐ PPO ☐ Other: _____

Authorization #: _____ Expiration Date: _____

If insurance is HMO-Medical Group: ☐ Alpha Care ☐ Healthcare Partners ☐ Primecare Chino Valley

☐ ProMed Pomona Valley ☐ Other: _____

Subscriber's Name: _____

Birthdate: _____ Gender: _____

Relationship to Patient:_____

Policy ID #: _____Group #: _____

Subscriber's Home Address: _____

Phone #: ( )_____

ADVANCE DIRECTIVE FOR HEALTHCARE: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No Who is proxy agent?_____

Relationship: _____

Phone #: ( )_____ ☐ Home ☐ Work ☐ Cell

Have you been vaccinated against COVID-19? ☐ Yes ☐ No

If yes, date of last dose _____ Vaccine: ☐ Pfizer ☐ Moderna ☐ J & J

Have you been vaccinated against Influenza? ☐ Yes ☐ No If yes, date _____

"Please Protect Yourself"- Your Insurance Company may require that you obtain pre-authorization for your hospital stay. Please remember to check with your plan prior to your hospital admission.