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 p	eriod:		
Obstetrician (OB):			Pediatrician (PE	:DS):			
I am expecting a:	☐ Vaginal delivery		Primary Care M	D			
	☐ Cesarean section						
-	a patient at Pomona						
If yes, date	of most recent visit: _						
LEGAL NAME							
Last Name:			First Nam	ne:			
Middle Initi	al:						
Name used at prior	visit (if different):						
Other Names Used/N	Maiden Name:						
Patient's Social Secu	rity #:						
Birthdate: Birthpla				lace:			
Email Address:							
Home Address (do n	not use P.O. Box #):						
Primary Contact Pho	one #: ()				☐ Home	□ Work	□ Cell
Race:	Ethnicity:	☐ Hispanic	☐ Other				
Organ Donor: 🗆 Ye							
•	: □ Married □ Sir	ngle					
_	Domestic Partner						
	rated Divorced						
Primary language: _			Religion:		Occupation	n:	
Patient's Employer:_			Address:				
City:	S	tate:			Zip:		
Employer Phone #:	()						
Work Status: □ Fu	II Time □ Part Time						
Person to Notify/Em	nergency Contact Nam	e:					
Primary Contact Pho					☐ Home	□ Work	□ Cell



METHOD OF PAYMENT: ☐ Self-I	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:					
•	Group #:				
Subscriber's Home Address:					
Phone #: ()					
SECONDARY INSURANCE PLAN:					
Insurance Phone #: ()	one #: () □ 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 HEALTHCA	RE: □ Yes □ No				
Living Will: ☐ Yes ☐ No					
Power of Attorney: ☐ Yes ☐ No V	Vho is proxy agent?				
	□ Home □ Work □ Cell				
Have you been vaccinated against CO					
	Vaccine: □ Pfizer □ Moderna □ J & J				
	luenza? □ 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.

