POMONA VALLEY HOSPITAL
MEDICAL CENTER

PLEASE PRINT
請用清晰工整字體填寫

CONFIDENTIAL Labor & Delivery OB Pre Registration on Form

Welcome to Pomona Valley Hospital Medical Center, your registration on form will be processed no later than 2 months prior to your due date. If you do not receive a confirmation on e-mail 2 months before your due date, contact our Pre Service Department at 909-469-9395. Please print legibly and or fill out this form electronically. Also please make sure you check mark the correct boxes. Please click the **Submit** button. Thank you and we look forward to serving you for your maternity stay.
請用英文填寫此表
歡迎來到波莫納谷醫院醫療中心, 您的註冊表會在您的預產期之前兩個月內處理。如果您在預產期前兩個月仍未收到確認的 電子郵件, 請致電 909-469-9395與我們的預先服務部門聯繫。請用清晰工整字體填寫, 或在電腦上填寫此表格。另外, 請確 保勾選正確的選框。請點擊"提交"按鈕。感謝您。我們期待在您的孕產期間爲您服務。

Due Date/預產期:_____

1st day of Last menstrual period/末次月經首日日期: _____

Obstetrician/產科 _(OB) 醫生:_____

Pediatrics/兒科 _(PEDS) 醫生: _____

I am expecting a/我打算 ☐ Vaginal delivery/自然生產
☐ Cesarean section/剖腹產

Primary Care MD/家庭醫生/內科醫生/全科醫生: _____

Have you ever been a patient at Pomona Valley Hospital Medical Center?/您是否曾經來波莫納谷醫院醫療中心就醫 ☐ Yes/有 ☐ No/無
If yes, date of most recent visit/_如有, 最近一次就醫日期:_____

LEGAL NAME/法定姓名:
Last Name/姓:_____ First Name/名:_____ Middle Initial/中間名起始字母:_____

Name Used at prior visit (if different)/先前就醫使用姓名 _(如與上述不同):_____
Other Names Used/Maiden Name/別名/婚前姓名:_____
Patient's Social Security #/產婦社安號#:_____ Birthdate/出生日期(月/日/年):_____Birthplace/出生地點:_____
Email Address/電子郵箱:_____

Home Address (do not use P.O. Box#)/家庭住址 **_(**請勿填寫郵箱號碼**):** _____
City/城市: _____State/州: _____ Zip/郵編: _____
Primary Contact#/主要聯絡電話#: (____)_____ ☐ Home/住家 ☐ Work/工作 ☐ Cell/手機
Race/種族:_____Ethnicity/族裔: ☐ Chineese/西裔 ☐ Other/其他_____ Organ Donor/器官捐獻者: Yes/是 ☐ No/否 ☐
Legal Marital Status/法定婚姻狀況: ☐ Married/已婚 ☐ Registered Domestic Partner/登記同性伴侶
☐ Legally Separated/登記同性伴侶 ☐ Divorced/離婚 ☐ Other/其他:_____

Primary language(s)/主要使用語言:_____ Religion/信仰:_____Occupation/職業:_____
Patient's employer/產婦雇主:_____ Address/地址: _____
City/市:_____State/州:_____Zip/郵編:_____
Employer Phone#/雇主電話#: (____)_____ Work Status/工作現況: ☐ Full Time/全職 ☐ Part Time/兼職

Person to Notify/Emergency Contact Name/緊急聯絡人姓名:_____
Relationship/與患者關係: _____ Primary Contact#/主要聯絡電話#: (____)_____ ☐Home/住家 ☐Work/工作 ☐Cell/手機

METHOD OF PAYMENT/付款方式: ☐ Self-Pay/自付 ☐ Primary Insurance/主要健保計劃 ☐ Secondary Insurance/次要健保計劃

PRIMARY INSURANCE PLAN/主要健保計劃:_____
Insurance Phone#/保險公司電話#: (____)_____ ☐ HMO ☐ MediCal ☐ PPO ☐ Other/其他: _____
Authorization #/授權#: _____ Expiration Date/到期日期: _____

If insurance is HMO- Medical Group/如保險為 **_HMO-** 健保集團: ☐ Alpha Care ☐ Healthcare Partners ☐ Primecare Chino Valley
☐ ProMed Pomona Valley ☐ Other/其他 _____
Subscriber's Name/投保人姓名: _____Birthdate/出生日期(月/日/年):_____ Gender/性別:_____
Relationship to Patient/與產婦關係: _____Policy ID#/保單號#:_____Group #/團體號 #:_____
Subscriber's Home Address/投保人家庭住址: _____ Phone #/電話 _#: (____)_____

SECONDARY INSURANCE PLAN/次要健保計劃:_____
Insurance Phone#/保險公司電話#: (____)_____ ☐ HMO ☐ MediCal ☐ PPO ☐ Other/其他: _____
Authorization #/授權#: _____ Expiration Date/到期日期: _____

If insurance is HMO- Medical Group/如保險為 **_HMO-** 健保集團: ☐ Alpha Care ☐ Healthcare Partners ☐ Primecare Chino Valley
☐ ProMed Pomona Valley ☐ Other/其他 _____
Subscriber's Name/投保人姓名: _____Birthdate/出生日期(月/日/年):_____ Gender/性別:_____
Relationship to Patient/與產婦關係: _____Policy ID#/保單號#: Group #/團體號 #:_____
Subscriber's Home Address/投保人家庭住址: _____ Phone #/電話 _#: (____)_____

ADVANCE DIRECTIVE FOR HEALTHCARE/醫療照護事前指示: ☐ Yes/是 ☐ No/否 **Living Will/**生前遺囑: ☐ Yes/是 ☐ No/否
Power of Attorney/醫療代理人: ☐ Yes/是 ☐ No/否 Who is proxy Agent/醫療代理人姓名:_____
Relationship:_____ Phone#: (____)_____ ☐Home/住家 ☐ Work/工作 ☐Cell/手機

"Please Protect Yourself"- Your insurance company may require that you obtain pre-authorization on for your hospital stay. Please remember to check with your plan prior to your hospital admission.
"請保護好自身權益**"-** 您的保險公司可能會要求您事先獲得住院許可。請記住在您入院之前先核對一下您的健保計劃。