Huntington Hospital

Labor & Delivery Pre-Registration Form

Your paperwork will be processed no later than 2 months prior to your due date. If you do not receive a confirmation letter 2 months before your due date, contact the Call Center manager at (626) 397-5606. Please print legibly and check (✓) the correct boxes. Return form by fax or mail. Please fax completed form to (626) 397-7149. Thank you.

Due Date: ________________________ 1st day of Last menstrual period: ______________ Obstetrician: ____

I'm expecting a ❑ Vaginal delivery ❑ Cesarean section Primary Care MD/Internist/GP: ____

Have you ever been a patient at Huntington Hospital? ❑ Yes ❑ No If yes, date of most recent visit: ______________________________

LEGAL NAME: Last name: ________________________________ First name: ________________________________ Middle initial: __________

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 #: (_____) ____________________ ❑ Home ❑ Work ❑ Cell

Race: ____________________ Ethnicity: ❑ Hispanic ❑ Other Secondary Contact #: (_____) ____________________ ❑ Home ❑ Work ❑ Cell

Legal Marital status: ❑ Married ❑ Single ❑ Registered Domestic Partner ❑ Legally Separated ❑ Divorced ❑ Other: ____________________
(For Birth Certificate Purposes)

Primary language(s): ____________________________ Religion: ________________ Occupation: ______________________________

Patient's employer: ____________________________ Address: ____

City: ____________________ State: ______ Zip: __________ Employer phone (_____) ______________ Work status: ❑ Full Time ❑ Part Time

Person to Notify/Emergency Contact: ____ Relationship: ______________________________

Primary Contact#: (_____) ______________ ❑ Home ❑ Work ❑ Cell Secondary Contact#: (_____)______________ ❑ Home ❑ Work ❑ Cell

METHOD OF PAYMENT: ❑ Self Pay ❑ Primary Insurance ❑ HMO ❑ PPO ❑ Other ________________ ❑ Medi-Cal# ____________________
If insurance is HMO: ❑ Medical Group ❑ Healthcare Partners ❑ Physicians' Assc. ❑ Other ______________________________________
Include a copy of insurance card (back and front) when sending or faxing form.

PRIMARY INSURANCE PLAN: ____ Ins Phone: (_____)________________

Subscriber's name: ________________________________ Birthdate: ____________ Subscriber's Soc. Security #: ______________________

Relationship to Patient: ______________________ Policy ID#: ________________________________ Group #: ______________________

Subscribers Home address: ____ Phone: (_____)________________

Subscriber's employer: ____ Phone: (_____)________________

Employer address: ____ Work status: ❑ Full Time ❑ Part Time ❑ Other ______________

SECONDARY INSURANCE PLAN: ____ Ins Phone: (_____)________________

❑ HMO ❑ PPO ❑ Other ____ ❑ Medi-Cal
If insurance is HMO: ❑ Medical Group ❑ Healthcare Partners ❑ Physicians' Assc. ❑ Other ____________________________

Subscriber's name: ________________________________ Birthdate: ____________ Subscriber's Soc. Security #: ______________________

Relationship to Patient: ______________________ Policy ID#: ________________________________ Group #: ______________________

Subscribers Home address: ____ Phone: (_____)________________

Subscriber's employer: ____ Phone: (_____)________________

Employer address: ____ Work status: ❑ Full Time ❑ Part Time ❑ Other ______________

ADVANCE DIRECTIVE FOR HEALTH CARE: ❑ Yes ❑ No **Living Will:** ❑ Yes ❑ No **Power of Attorney:** ❑ Yes ❑ No

Who is proxy Agent: __________________________ Relationship: ________________ Phone: ______________ ❑ Home ❑ Work ❑ Cell

FOR PRE-REGISTRATION QUESTIONS, PLEASE CONTACT THE CALL CENTER: (626) 397-5600

MAIL IN COMPLETED LABOR & DELIVERY REGISTRATION FORM TO:
Huntington Hospital Attn: Call Center 100 W. California Blvd., Pasadena CA 91109-7013 **OR** Fax to: (626) 397-7149