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 2138. 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) 397-2138