



Pre Admission Information

30 days prior to your due date, please go to the Admitting Office at Redlands Community Hospital to sign your consents forms.

Please write legibly your LEGAL NAME as shown on your Drivers License (no nicknames)

EXPECTED DUE DATE ___/___/___ Twins Y/N Surrogate Y/N

Patient Name: _____ Date of Birth ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Religious Preference _____ Affiliated Church _____ Social Security # _____

Drivers License# _____ Email address _____

Preferred Pharmacy: _____ City: _____ Street: _____

Single / Married / Divorced / Separated / Widowed Race: _____ Ethnicity: _____

(Please circle one)

Primary Physician: _____ Obstetrician: _____ Pediatrician: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____ Part Time OR Full Time _____

Primary Insurance: _____ Policy#/Member ID# _____

Group# _____ Name of Subscriber: _____ Relationship _____

Subscribers date of birth: ___/___/___ Subscribers Social Security# _____

Subscribers Employer: _____ Address: _____

Secondary Insurance: _____ Policy# /Member ID# _____

Group# _____ Name of Subscriber: _____ Relationship _____

Subscribers date of birth: ___/___/___ Subscribers Social Security# _____

Subscribers Employer: _____ Address: _____

Person to make Medical Decisions if you are unable:

2nd Emergency Contact:

Name: _____

Name: _____

Address: _____

Address: _____

Phone# _____

Phone# _____

Relationship to You: _____

Relationship to You: _____