Scripps

MATERNITY PRE-ADMISSION INFORMATION
Please print clearly and complete all information requested

PLEASE COMPLETE AND RETURN THIS FORM IMMEDIATELY:

PATIENT

PHYSICIAN

DUE DATE

PATIENT INFORMATION Have you ever been a patient at this hospital? ☐ Yes ☐ No

If yes, what year? _____ Under what name? _____

Patient's name: _____

Address _____ Phone No. (_____) _____

City _____ State _____ Zip _____

Marital Status _____ Patient's SS# _____-_____-_____ Birth Date _____ Birthplace _____

Patient's Maiden Name _____ Race _____ Language _____ Veteran ☐ Yes ☐ No

Allergies _____ Religious Belief _____

First day of last period _____ Expected Delivery Date _____

Obstetrician _____ Pediatrician _____ Primary Care Provider _____

Do you have a signed Organ Donation Card? Yes / No Do you have an Advance Directive for Healthcare? Yes / No

Employer _____ Employer Address _____

Work Phone # (_____) _____ ext._____ Full or Part Time _____ Occupation _____

Driver's License/ID# _____ State _____ Expiration _____

SPOUSE OR EMERGENCY CONTACT *(Someone inside the home)*

Full Name _____ Relation _____

Home Phone #(_____) _____ Work Phone # (_____) _____

Employer _____ Employer Address _____

Full or Part Time _____ Occupation _____

SS# _____-_____-_____ Birth Date _____

NEAREST RELATIVE OR FRIEND *(Someone outside the home)*

Full Name _____ Relation _____

Address _____

Home Phone # (_____) _____ Work Phone # (____) _____ ext._____

INSURANCE INFORMATION Cash Pay ☐ Yes ☐ No Pre-paid Cash Program ☐ Yes ☐ No Medical Insurance ☐

NOTE: PLEASE ENCLOSE COPIES OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S). List _____

Signature _____ Date _____

Please indicate your room preference. While room requests are not guaranteed, preference will be honored whenever possible. It is important to note that most insurance companies do not pay for private accomodations.

◯ Private ◯ Semi-Private

Please enclose a copy of insurance card, front and back. For cash accounts and/or to make arrangements for deductables or co-pays, contact (619) 686-3924.

You may also include your complete Patient Profile now or bring it when you come to the hospital.

Re-fold to original size, moisten gum strip and seal. Mail promptly! For your convenience, postage is paid.

Thank you.

Scripps

Scripps Mercy Hospital
ATTN: Maternity Admitting
4077 Fifth Avenue, MER4
San Diego, CA 92103-9988
(619) 686-3924

Dear Parents to Be:

Thank you for selecting Scripps for your delivery. The information on this pre-admission sheet is needed for your hospital records. By completing and returning this to the hospital IN ADVANCE, we can plan and facilitate your admission.

Please call the phone number below if you need financial information or insurance information.

We at Scripps look forward to meeting your healthcare needs. Please call our Administrative Partners at (619) 686-3924 for any other assistance you may need.

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ADMINISTRATIVE PARTNERS
SCRIPPS MERCY HOSPITAL
MER4
4077 FIFTH AVENUE
SAN DIEGO CA 92103-9988

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Maternity Pre-Admission Questionnaire