PRE-ADMITTING FORM

CONFIDENTIAL

Please complete this preregistration form and return it to the Admitting Department at Community Hospital of San Bernardino.

When you arrive at the hospital, your paperwork will be complete and you can concentrate your efforts on a safe and healthy delivery. All you need to do at the time of admission or pre-admisson is show your identification and medical insurance cards.

Have you previously been treated at Community Hospital of San Bernardino? ❑ Yes ❑ No

PATIENT

DUE DATE

LAST NAME (PATIENT) | FIRST NAME | MIDDLE | BIRTH NAME

HOME ADDRESS / APARTMENT / SPACE NUMBER | CITY | ZIP CODE | TELEPHONE / CELL NUMBER

BIRTH DATE | MARITAL STATUS | RELIGION | E-MAIL ADDRESS

BIRTH PLACE | PRIMARY LANGUAGE | SOCIAL SECURITY NUMBER | DRIVER LICENSE NUMBER

EMPLOYER | OCCUPATION

BUSINESS / EMPLOYER ADDRESS | CITY | ZIP CODE | TELEPHONE NUMBER

MATERNITY

TYPE OF ADMISSION

PHYSICIAN NAME | ADDRESS | TELEPHONE NUMBER

SPOUSE

LAST NAME (SPOUSE) | FIRST NAME | MIDDLE | SOCIAL SECURITY NUMBER

ADDRESS | CITY | ZIP CODE | TELEPHONE / CELL NUMBER

BIRTH DATE | EMPLOYER | CITY | TELEPHONE

Notify in Case of Emergency (Other than Spouse)

LAST NAME | FIRST NAME | MIDDLE | RELATION TO PATIENT

ADDRESS | CITY | ZIP CODE | TELEPHONE / CELL NUMBER

INSURANCE

PRIMARY INSURANCE COMPANY NAME | POLICY HOLDER NAME | RELATION TO PATIENT

POLICY HOLDER ADDRESS | CITY | ZIP CODE | TELEPHONE

SOCIAL SECURITY NUMBER | GROUP NAME / ID NUMBER

SECONDARY INSURANCE COMPANY NAME | POLICY HOLDER NAME | RELATION TO PATIENT

POLICY HOLDER ADDRESS | CITY | ZIP CODE | TELEPHONE

SOCIAL SECURITY NUMBER | GROUP NAME / ID NUMBER

Please send this form to:
Community Hospital of San Bernardino
Admitting Department
1805 Medical Center Drive
San Bernardino, CA 92411

Dignity Health.
Community Hospital of San Bernardino

Maternal Child Services