

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-admission 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:
St. Bernardine Medical Center
Maternal Child Education Department
2101 N. Waterman Avenue
San Bernardino, CA 92404



Dignity Health[™]
St. Bernardine Medical Center

Maternal Child Services