

# 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

<b>PRIMARY INSURANCE</b> COMPANY NAME	POLICY HOLDER NAME	RELATION TO PATIENT	
POLICY HOLDER ADDRESS	CITY	ZIP CODE	TELEPHONE
SOCIAL SECURITY NUMBER	GROUP NAME / ID NUMBER		
<b>SECONDARY INSURANCE</b> 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**<sup>™</sup>  
Community Hospital of  
San Bernardino

**Maternal Child Services**