Dignity Health
California Hospital
Medical Center

PRE – REGISTRATION FORM

OB: _____
DO NOT WRITE IN THIS SPACE

ADMITTING CLINIC: _____ DUE DATE: _____/_____/_____

PATIENT INFORMATION:

ETHNIC ORIGIN (optional): _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY #: _____ BIRTH PLACE: _____

MARITAL STATUS: _____ DRIVER LICENSE/ID #: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE NUMBER: ( ) _____-_____ E-MAIL: _____

OCCUPATION: _____ COMPANY NAME: _____ EMPLOYER PHONE #: ( ) _____-_____

PREVIOUSLY HOSPITALIZED IN THIS HOSPITAL (DATE): ____/____/____ UNDER WHAT NAME: _____

EMERGENCY CONTACT:

LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: ( ) _____-_____ ADDITIONAL NUMBER: ( ) _____-_____

LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: ( ) _____-_____ ADDITIONAL NUMBER: ( ) _____-_____

INSURANCE INFORMATION:

MEDI-CAL ID#: _____HEALTH PLAN: _____ GROUP#: _____

PRIVATE INSURANCE NAME: _____ GROUP#: _____ ID#: _____
Policy Holder: _____ Relationship to patient: _____
Policy Holder Social Security #: _____
Employers Name: _____ Phone Number: ( ) _____-_____
Employers Address: _____City: _____ Zip Code#: _____

SIGNATURE: _____ DATE: _____/_____/_____