SAN ANTONIO REGIONAL HOSPITAL

Maternity Pre-Admission Form

This form contains information to begin your medical record and to verify your insurance. Please complete the form and return it by mail or fax (909.694.1080) to the Hospital Admitting Department as soon as possible, prior to your scheduled arrival date. If possible, please attach a copy of your insurance card to the form.

Obstetrical patients: Please complete the form and return it to the Hospital Admitting Department prior to your fifth month of pregnancy.

Patient Information (Please Print)

DOCTOR'S NAME		PRIMARY CARE PHYSICIAN				MEDICAL GROUP							
EXPECTED DELIVERY DATE		PEDIATRICIAN NAME				MARITAL STATUS	M	S	W	D	SEP	LIFE PARTNER	
LAST NAME		FIRST NAME		MIDDLE NAME		EMAIL ADDRESS							
STREET ADDRESS				CITY		STATE	ZIP						
DATE OF BIRTH		HOME PHONE		CELL PHONE		MAIDEN NAME							
SOCIAL SECURITY NUMBER		BIRTH PLACE (STATE)		RACE / ETHNIC GROUP		RELIGION							
EMPLOYER		ADDRESS											
CITY		STATE	ZIP	PHONE & EXTENSION									
HAVE YOU BEEN A PATIENT AT THIS HOSPITAL? YES ☐ NO ☐		DRIVER'S LICENSE #		OCCUPATION/EMPLOYER									
ARE YOU A SURROGATE? YES ☐ NO ☐													

Insurance Information (Please Print)

DO YOU HAVE INSURANCE FOR THIS HOSPITALIZATION? YES ☐ NO ☐ IF NO, PLEASE CALL 909.920.4826.							
SUBSCRIBER NAME		SOCIAL SECURITY NUMBER		RELATIONSHIP TO YOU		DATE OF BIRTH	
PRIMARY INSURANCE	GROUP NUMBER		SECONDARY INSURANCE / SUBSCRIBER		GROUP NUMBER		
EMPLOYER	MEMBER NUMBER		EMPLOYER		MEMBER NUMBER		
ADDRESS / CITY / STATE / ZIP			ADDRESS / CITY / STATE / ZIP		DATE OF BIRTH		
INS BILLING ADDRESS / CITY / STATE / ZIP	PHONE NUMBER		INS BILLING ADDRESS / CITY / STATE / ZIP		PHONE NUMBER		

INSURANCE BILLING IS HANDLED AS A COURTESY TO THE PATIENT.

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Emergency Contacts / Family Spokesperson / Additional Information (Please Print)

EMERGENCY CONTACT NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
FAMILY SPOKESPERSON NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		
ALTERNATE DECISION MAKER NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		
ALTERNATE EMERGENCY CONTACT NAME		HOME OR CELL PHONE		
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO YOU
CAN WE SHARE BILLING INFORMATION WITH THIS PERSON? YES ☐ NO ☐		CAN WE SHARE CLINICAL INFORMATION WITH THIS PERSON? YES ☐ NO ☐		

PLEASE BRING INSURANCE CARD(S) AND CLAIM FORMS.

MAY WE GIVE CAIR (CALIFORNIA IMMUNIZATION REGISTRY) PERMISSION TO SHARE YOUR/YOUR CHILD'S IMMUNIZATION INFORAMTION WITH YOUR PHYSICIAN AND/OR SCHOOL FOR YOUR CONVENIENCE? YES ☐ NO ☐

DO YOU HAVE ANY ALLERGIES? YES ☐ NO ☐ DO YOU HAVE AN ADVANCE DIRECTIVE? YES ☐ NO ☐
(IF YES, PLEASE BRING A COPY TO THE HOSPITAL)

4MYHEALTH - SAN ANTONIO REGIONAL HOSPITAL OFFERS A SECURE, ONLINE SITE THAT ALLOWS YOU EASY ACCESS TO YOUR ELECTRONIC HEALTH INFORMATION. IF YOU WOULD LIKE TO ACCESS YOUR ELECTRONIC HEALTH INFORMATION IN THIS MANNER, PLEASE COMPLETE THE FOLLOWING:
EMAIL ADDRESS:
PASSWORD (SELECT ONE) LAST 4 DIGITS OF YOUR SOCIAL SECURITY NUMBER ANSWER:
YEAR YOU GOT MARRIED
YEAR YOU GRADUATED
BIRTH YEAR

VALUABLES: JEWELRY, ELECTRONIC DEVICES, MONEY IN LARGE AMOUNTS, OR OTHER VALUABLES SHOULD NOT BE BROUGHT TO THE HOSPITAL.

I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY OR OTHER THIRD PARTY PAYORS.

DATE SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS A MINOR)

THANK YOU FOR CHOOSING SAN ANTONIO REGIONAL HOSPITAL.

MKT0045E 082025