KAISER PERMANEJMTE® LABOR AND DELIVERY PREADMISSION WORKSHEET

Expected date of delivery:Medical Record Number:

Dear Parent-to-be: To ensure accurate information, please complete this form in its entirety and return to the Admitting Department. As a Kaiser Permanente patient, you may have a hospital fee, deductible, copayment, or coinsurance which you are required to pay at the time of admission. If you would prefer to make a payment in advance of your admission, please call or visit the Admitting Department. Thank you.

Patient Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	MAIDEN NAME

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

Ethnicity
- ☐ Hispanic / Latino—Other
- ☐ Non-Hispanic/ Non-Latino

Marital Status
- ☐ Common Law
- ☐ Married
- ☐ Single / Never Married
- ☐ Divorced
- ☐ Registered Domestic Partner
- ☐ Widowed
- ☐ Legally Separated
- ☐ Separated
- ☐ Other

During your admission, we have your permission to disclose *(check all applicable boxes):*
- ☐ Name
- ☐ Condition
- ☐ Location / Phone
- ☐ Religion
- ☐ No Information / Confidential Admit

Clergy visit?
- ☐ Yes
- ☐ No

Race
- ☐ Asian / Pacific Islander—Other Asian
- ☐ Asian / Pacific Islander—Other Pacific Islander
- ☐ Black—Other Black
- ☐ Native American / Eskimo / Aleutian—Other
- ☐ White — Other White or European
- ☐ Other
- ☐ Unknown

RELIGION	PREFERRED SPOKEN LANGUAGE	PREFERRED WRITTEN LANGUAGE

EMPLOYER

ADDRESS	CITY	STATE	ZIP

PHONE	EMPLOYMENT STATUS	OCCUPATION

Emergency Contacts

PRIMARY CONTACT NAME	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

SECONDARY CONTACT NAME	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

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Newborn Information

Ethnicity	Race	
Hispanic/Latino—Other	Asian / Pacific Islander—Other Asian	Other
Non-Hispanic / Non-Latino	Asian / Pacific Islander—Other Pacific Islander	Unknown
	Black—Other Black	White— Other White or European
	Native American / Eskimo / Aleutian—Other	

Advance Directive Information

Do you have an Advance Health Care Directive? Yes No

If yes, please provide a copy to the Admitting Department.

Subscriber Information

NAME		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	STATE	ZIP
Male / Female	DATE OF BIRTH	HOME PHONE	
EMPLOYER		EMPLOYMENT STATUS	
EMPLOYER ADDRESS	CITY	STATE	ZIP
OCCUPATION		WORK PHONE	

Other Insurant:e Information

SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	STATE	ZIP
Male / Female	DATE OF BIRTH	HOME PHONE	
SUSCRIBER EMPLOYER		EMPLOYMENT STATUS	
EMPLOYER ADDRESS	CITY	STATE	ZIP
OCCUPATION		WORK PHONE	
MEDICARE CLAIM NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	
MEDI-CAL BENEFITS ID NO.	MEDI-CAL ISSUE DATE		
OTHER INSURANCE COMPANY	GROUP NO.	INSURANCE ID	
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP
INSURANCE PHONE	EFFECTIVE DATE OF INSURANCE COVERAGE		