



**CEDARS-SINAI MEDICAL CENTER<sup>®</sup>**

**Pre-Admission Form  
for  
Maternity Services**

Please print this application form and send to us by either:

Mail



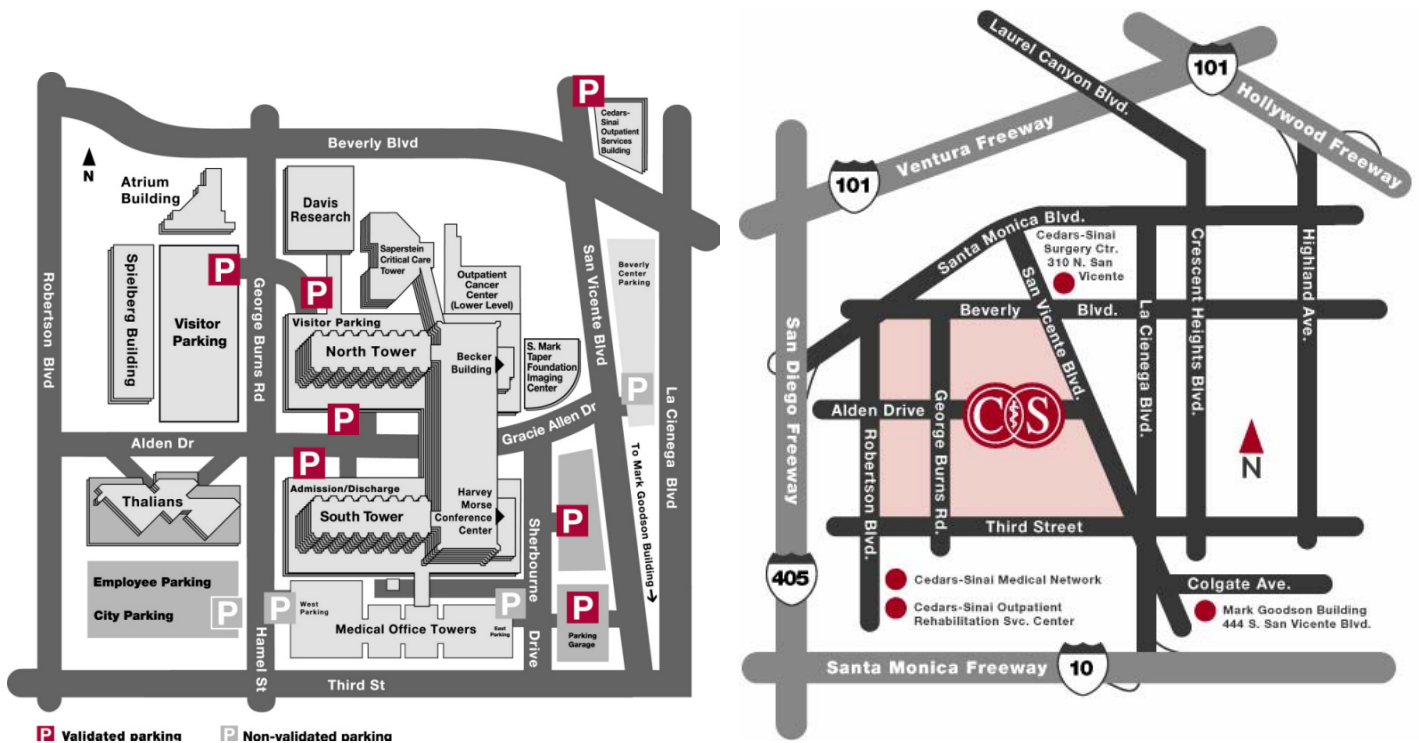
**Maternity Services**  
8700 Beverly Blvd., Room 3417  
Los Angeles, CA 90048

Fax (310) 423-0104

**Information:** If you have any questions, please call (310) 423-3798.

**Maternity Tour:** Expectant parents are invited to take a complimentary tour of our Maternity Center. The tour is a wonderful opportunity to become acquainted with our facility and services as well as to meet our Medical Center staff. A telephone reservation is required. Private tours are available. Call (310) 423-5168 to schedule.

**Education Programs:** For information on our education programs call (310) 423-5168 or visit the Prenatal Education Website and register for classes online at [www.csmc.edu/7119.html](http://www.csmc.edu/7119.html)



Cedars-Sinai Medical Center's campus is located at 8700 Beverly Boulevard in Los Angeles. It is bordered to the east by San Vicente Boulevard, to the south by Third Street and to the west by Robertson Boulevard.

From the Santa Monica Freeway (10), exit at La Cienega Boulevard. Proceed north to the Medical Center, just north of Third Street. From the Hollywood Freeway (101), exit at Highland Avenue. Proceed south to Beverly Boulevard. Turn right and proceed to the Medical Center at San Vicente Boulevard. Turn left.

## Patient Information

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Religious Preference \_\_\_\_\_ Birthplace \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Calif. Driver's License or ID \_\_\_\_\_  
Marital Status:  Married  Domestic Partnership  Single  Divorced  Separated  
Ethnicity:  Hispanic  Non-Hispanic  
Race:  Caucasian  Black  Asian/Pacific Islander  Native American/Eskimo/Aleut  Other  
Maiden Name \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Estimated Date of Delivery \_\_\_\_\_ Pediatrician \_\_\_\_\_  
Your Obstetrician's Name \_\_\_\_\_  
Have you been at this hospital before?  Yes  No If yes, when \_\_\_\_\_  
Under what name(s)? \_\_\_\_\_

## Patient Employment Information

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer Street Address \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

## Spouse/Partner Information

Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth date \_\_\_\_\_  
Ethnicity:  Hispanic  Non-Hispanic  
Race:  Caucasian  Black  Asian/Pacific Islander  Native American/Eskimo/Aleut  Other  
Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer Street Address \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Paternity Declaration** *A new California law requires that unmarried fathers sign a Declaration of Paternity if they wish their names to appear on birth certificates. The declaration may be signed while the child is in the hospital and turned in with the birth certificate worksheet. If it is signed after the child is discharged from the hospital, the father must pay a fee to have the birth certificate amended. Our Birth Records department will provide informational materials, as well as the declaration form.*

## Guarantor/Subscriber/Responsible Person

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
Employer Street Address \_\_\_\_\_ Suite. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth date \_\_\_\_\_ Social Security \_\_\_\_\_ Other ID \_\_\_\_\_  
Work Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

## Emergency Notification

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

## Insurance Information

Name of Insurance Company or Administrator \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_  
Name of Insured Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Social Security No. \_\_\_\_\_ Policy Group No. \_\_\_\_\_  
Is an authorization for treatment required by your health plan?  Yes  No  
Effective Date \_\_\_\_\_ Annual deductible \_\_\_\_\_ % Coverage \_\_\_\_\_  
Secondary Insurance Company or Administrator, if any \_\_\_\_\_  
Street Address \_\_\_\_\_ Suite. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Social Security No. \_\_\_\_\_ Policy Group No. \_\_\_\_\_  
Is an authorization for treatment required by your health plan?  Yes  No  
Effective Date \_\_\_\_\_ Annual deductible \_\_\_\_\_ % Coverage \_\_\_\_\_

For all insured patients, a copy of your current insurance card (front and back) is required.  
I certify that the above information is correct and accurate to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Representative's Signature

\_\_\_\_\_  
Date