

# Labor & Delivery Registration

Please complete this form, fold and tape it shut and drop it in the mail. Your paperwork will be processed no later than 2 months prior to your due date. You will receive a letter confirming we received your form within 2 weeks after mailing it in. If you do not receive a confirmation letter 2 months before your due date, contact the Call Center manager at (626) 397-5606. When filling out the form, please print and check (✓) the correct boxes. Thank you.



100 W. California Boulevard  
Pasadena, California 91105  
Call Center phone (626) 397-5600, Option 4

Due Date: \_\_\_\_\_ 1st day of last menstrual period: \_\_\_\_\_ Obstetrician: \_\_\_\_\_

I'm expecting a  Vaginal delivery  Cesarean section

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Prior last name: \_\_\_\_\_ AKA: \_\_\_\_\_

Home address (do not use P.O. Box #): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Birth date: \_\_\_\_\_ Birthplace - city and state: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity:  Hispanic  Other

Patient's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital status:  Married  Single  Other: \_\_\_\_\_

Primary language (spoken at home): \_\_\_\_\_ Religion: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last hospital admission (hospital name): \_\_\_\_\_ Admission/discharge dates: \_\_\_\_\_ / \_\_\_\_\_

Patient's employer: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer phone: (\_\_\_\_) \_\_\_\_\_ Hire date: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work Phone/Pager #: (\_\_\_\_) \_\_\_\_\_

Method of payment:  Self Pay  Insurance  Medi-Cal # \_\_\_\_\_ Issue date: \_\_\_\_\_

If your hospitalization will be covered by insurance, ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK) TO THIS REGISTRATION FORM and please complete the following:

Primary insurance subscriber's name: \_\_\_\_\_

Subscriber's Soc. Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Subscriber's employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Employer's address: \_\_\_\_\_ Occupation: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Primary Insurance Co.: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Primary Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Secondary Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

2nd insurance subscriber's name: \_\_\_\_\_ Employer: \_\_\_\_\_

Is your primary insurance plan a:  HMO  PPO  Indemnity  Other: \_\_\_\_\_

Is your physician associated with a provider/medical group?  Physician's Assoc.  Healthcare Partners  Select IPA

Other: \_\_\_\_\_

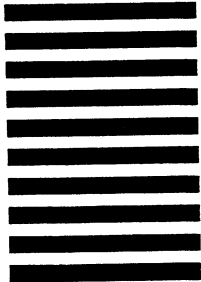
**Authorization to Release Information** - I hereby authorize the above named hospital to release information requested on this form.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

If you have any questions about filling out this form, call (626) 397-5600 and press "Option 4."



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NECESSARY  
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IN THE  
UNITED STATES



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**Huntington Memorial Hospital**  
P.O. Box 7013  
Pasadena, CA 91109-9963  
Attention: CALL CENTER

