KAISER PERMANENTE®

# Obstetrical Pre-Registration Form

☐ KSMC ☐ KWMC

☐ MA Verified Delivery Site on OB Episode

## Patient

| NAME: LAST | FIRST | MIDDLE | MAIDEN |
|---|---|---|---|
| ADDRESS: STREET, P.O. BOX, APT. NO. | | | |
| CITY: | STATE: | ZIP CODE: | SOCIAL SECURITY NUMBER: |
| NIGHT PHONE: | DAY PHONE: | ARE YOU A VETERAN? ☐ Yes ☐ No | |
| DATE OF BIRTH: | AGE: / RACE: | RELIGIOUS PREFERENCE: | MARITAL STATUS: |
| EMPLOYER: ☐ FULL TIME ☐ PART TIME | | ADDRESS: | |

## Next of kin

| NAME: LAST | FIRST | MIDDLE | RELATIONSHIP TO PATIENT: |
|---|---|---|---|
| ADDRESS: STREET, P.O. BOX, APT. NO. | | NIGHT PHONE: | DAY PHONE: |
| NAME: LAST | FIRST | MIDDLE | RELATIONSHIP TO PATIENT: |
| ADDRESS: STREET, P.O. BOX, APT. NO. | | NIGHT PHONE: | DAY PHONE: |

## Subscriber (individual who carries insurance coverage)

| NAME: LAST | FIRST | MIDDLE | PHONE: |
|---|---|---|---|
| ADDRESS: STREET, P.O. BOX, APT. NO. | | | |
| IS THERE OTHER INSURANCE COVERAGE? ☐ Yes ☐ No | | OTHER INSURANCE NAME: | |

## Subscriber's employer

| EMPLOYER: ☐ FULL TIME ☐ PART TIME | PHONE: |
|---|---|
| ADDRESS: STREET, P.O. BOX, APT. NO. | |

## Admission

| YOUR DUE DATE: |
|---|
| ARE YOU EXPECTING MULTIPLE BIRTHS? ☐ Yes ☐ No |
| YOUR PHYSICIAN/MIDWIFE: |

## For office use only

| ADMISSION DATE: | ROOM NUMBER: | TIME: |
|---|---|---|
| DIAGNOSIS: | | |
| PHYSICIAN: | | |
| BABY'S HEALTH RECORD NUMBER: | | BABY'S GENDER: |
| BIRTH TIME: | | NURSERY PHYSICIAN: |

14581 07/19 Ob/Gyn/KSMC/KWMC