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## **OB/GYN PRE-REGISTRATION FORM INSTRUCTIONS**

Expectant mothers should pre-register by the seventh month of pregnancy and complete the form on the other side of this document. The pre-registration process allows CMH to verify your insurance coverage and begin the pre-certification process and the pre-authorization process.

When you complete the form on the other side of this document please, bring it to the Admitting Department at Community Memorial Hospital located at 147 North Brent Street in Ventura.

**Monday - Friday 8AM - 8PM**

**Saturday and Sunday 8AM - 6PM**

With the pre-registration form you will be required to provide:

- Identification that includes your photograph and signature (such as your driver's license, state issued ID, or passport).
- Your insurance company information and identification card.
- The name of the pediatrician you have selected to care for your baby in the hospital (check your insurance to be sure you have selected a physician).

**For any questions regarding any of these issues please call the Admitting Department at: (805) 652-5049**





Due Date: \_\_\_\_\_ Center for Family Health: \_\_\_\_\_  
OB/GYN Doctor: \_\_\_\_\_ Pediatrician: \_\_\_\_\_  
Last Menstrual Period: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_ SSN: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Religion: \_\_\_\_\_ Race: \_\_\_\_\_

**PATIENT EMPLOYER:**

Company: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Status:  Full Time  Part Time  Self-Employed  Disabled  Unemployed

**SUBSCRIBER TO INSURANCE:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ U.S. Citizen:  Yes  No  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Status:  Full Time  Part Time  Self-Employed  Disabled  Unemployed

**INSURANCE INFORMATION:**

Primary Insurance Name: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Insurance Name: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: \_\_\_\_\_

**NEXT OF KIN:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_