



## PRE-REGISTRATION

Community Memorial Hospital is pleased to offer our patients a pre-registration service that allows us to verify all demographic and insurance information prior to your delivery. Expectant mothers should pre-register by the seventh month of pregnancy and complete the pre-admission form at the back of this brochure. The pre-registration process allows CMH to communicate with your insurance company to verify benefits and eligibility, start pre-certification, and obtain pre-authorization beforehand, so you can plan accordingly.

When you complete the form on the other side of this document please, bring it to the Admitting Department at Community Memorial Hospital.

**147 N. Brent St., Ventura, CA**  
**6:00 a.m. - 10:00 p.m. Daily**

Pre-Registration can also be completed at the conclusion of the Maternity Tours.

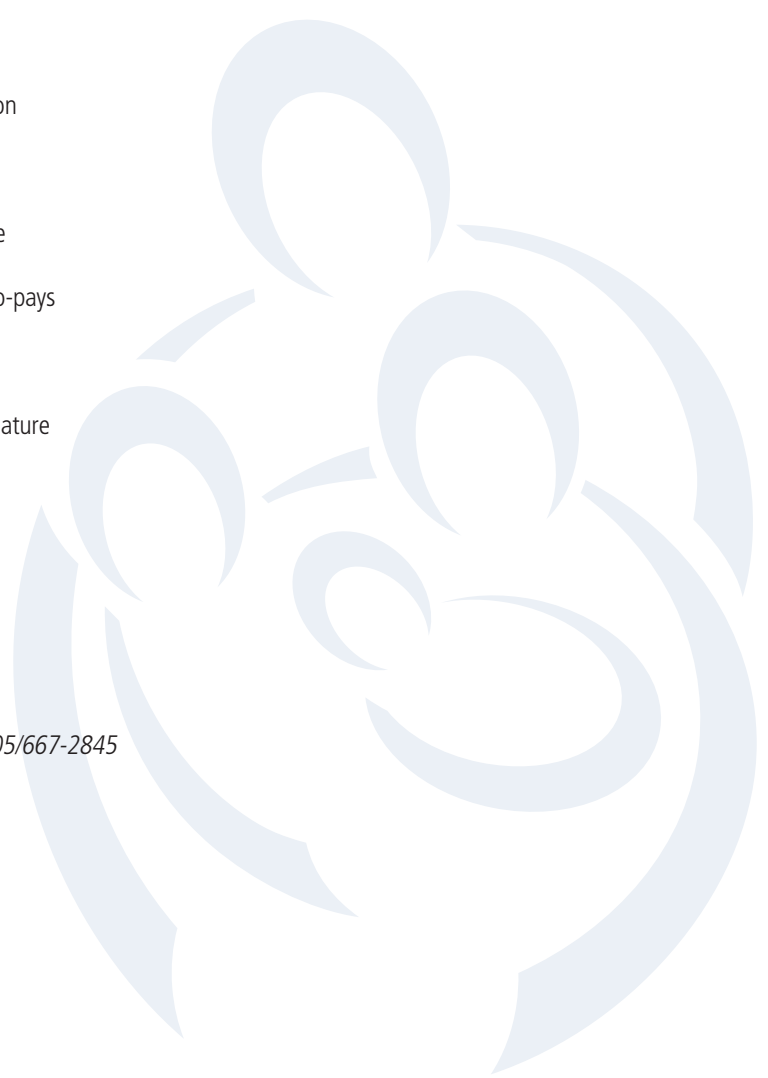
### ADVANTAGES OF PRE-REGISTRATION:

- Eliminates the stress of doing paperwork while you're in labor or in the hospital.
- Eliminates discharge delays by allowing you to pay co-pays and co-insurance before you are admitted.

### HAVE THE FOLLOWING INFORMATION READY:

- Identification that includes your photograph and signature (such as your driver's license).
- Name of the Pediatrician/Family Practice Physician who will care for your infant.
- Insurance company information/card.
- Name of your employer.
- Admitting date/due date.
- Social Security Number.
- Emergency notification numbers.

*For any questions on how to pre-register, please call 805/667-2845 and ask for the Admitting Department.*





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: \_\_\_\_\_  
 Baby will be added to your insurance plan.  
 Baby will be added to a different insurance plan. Name of insurance: \_\_\_\_\_

**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: \_\_\_\_\_