

# Please complete this pre-admitting form and return it to the Hospital.

# Pre-admitting Form Confidential

**Primary Language:**  English  Chinese  Vietnamese  Spanish

Today's Date \_\_\_\_\_ Expected Date of Delivery - Admission Date \_\_\_\_\_

## Pre-Admission Information

Obstetrician's Name \_\_\_\_\_ Pediatrician's Name \_\_\_\_\_

Patient's Name (Last, First, Middle) \_\_\_\_\_ Previous Name \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Patient's Home Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Home Phone No./Cell \_\_\_\_\_

Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_ Religion \_\_\_\_\_ Allergies \_\_\_\_\_

Patient's Employer \_\_\_\_\_  Smoker  Non-Smoker \_\_\_\_\_ Diabetic  Yes  No \_\_\_\_\_

Primary Insurance Holder \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Home Phone No./Cell \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer of Primary Insurance Holder \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Phone No. \_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_

Primary Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Phone No. \_\_\_\_\_

Primary Insured's Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Phone No. \_\_\_\_\_

Primary Insurance Group/Policy No. \_\_\_\_\_ Certificate or Social Security No. \_\_\_\_\_ Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Phone No. \_\_\_\_\_

Secondary Insured's Employer Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Phone No. \_\_\_\_\_

Secondary Insurance Group/Policy No. \_\_\_\_\_ Certificate or Social Security No. \_\_\_\_\_ Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Full Name \_\_\_\_\_ Relation \_\_\_\_\_ (Area Code) Home Phone No. \_\_\_\_\_

**In case of  
emergency: give  
name of nearest  
relative or friend**

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Cell Phone \_\_\_\_\_

Full Name \_\_\_\_\_ Relation \_\_\_\_\_ (Area Code) Home Phone No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (Area Code) Cell Phone \_\_\_\_\_

All insurance identification cards will be required at time of admission or preadmission.

Have you previously been treated at San Gabriel Valley Medical Center?  No  Yes

**Please send this form to:**

San Gabriel Valley Medical Center  
Women's Pavilion Pre-Admit  
438 W. Las Tunas Drive  
San Gabriel, California 91776-9938

