KAISER PERMANENTE® LABOR AND DELIVERY PREADMISSION WORKSHEET

Expected date of delivery: _____ Medical Record Number: _____

Dear Parent-to-be: To ensure accurate information, please complete this form in its entirety and return to the Admitting Department. As a Kaiser Permanente patient, you may have a hospital fee, deductible, copayment, or coinsurance which you are required to pay at the time of admission. If you would prefer to make a payment in advance of your admission, please call or visit the Admitting Department. Thank you.

Patient Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	MAIDEN NAME

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

Ethnicity

- ☐ Hispanic / Latino—Other
- ☐ Non-Hispanic / Non-Latino

Marital Status

- ☐ Common Law
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Registered Domestic Partner
- ☐ Separated
- ☐ Single / Never Married
- ☐ Widowed
- ☐ Other

During your admission, we have your permission to disclose *(check all applicable boxes):*

- ☐ Name
- ☐ Condition
- ☐ Location / Phone
- ☐ Religion
- ☐ No Information / Confidential Admit

Clergy visit?

- ☐ Yes
- ☐ No

Race

- ☐ Asian / Pacific Islander—Other Asian
- ☐ Asian / Pacific Islander—Other Pacific Islander
- ☐ Black—Other Black
- ☐ Native American / Eskimo / Aleutian—Other
- ☐ White—Other White or European
- ☐ Other
- ☐ Unknown

RELIGION	PREFERRED SPOKEN LANGUAGE	PREFERRED WRITTEN LANGUAGE

EMPLOYER

ADDRESS	CITY	STATE	ZIP

PHONE	EMPLOYMENT STATUS	OCCUPATION

Emergency Contacts

PRIMARY CONTACT NAME	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

SECONDARY CONTACT NAME	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE

ADDRESS	CITY	STATE	ZIP

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Newborn Information

Ethnicity

- ☐ Hispanic / Latino — Other
- ☐ Non-Hispanic / Non-Latino

Race

- ☐ Asian / Pacific Islander — Other Asian
- ☐ Asian / Pacific Islander — Other Pacific Islander
- ☐ Black — Other Black
- ☐ Native American / Eskimo / Aleutian — Other
- ☐ Other
- ☐ Unknown
- ☐ White — Other White or European

Advance Directive Information

Do you have an Advance Health Care Directive? ☐ Yes ☐ No

If yes, please provide a copy to the Admitting Department.

Subscriber Information

NAME	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP

☐ Male ☐ Female	DATE OF BIRTH	HOME PHONE

EMPLOYER	EMPLOYMENT STATUS

EMPLOYER ADDRESS	CITY	STATE	ZIP

OCCUPATION	WORK PHONE

Other Insurance Information

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP

☐ Male ☐ Female	DATE OF BIRTH	HOME PHONE

SUSCRIBER EMPLOYER	EMPLOYMENT STATUS

EMPLOYER ADDRESS	CITY	STATE	ZIP

OCCUPATION	WORK PHONE

MEDICARE CLAIM NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

MEDI-CAL BENEFITS ID NO.	MEDI-CAL ISSUE DATE

OTHER INSURANCE COMPANY	GROUP NO.	INSURANCE ID

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE PHONE	EFFECTIVE DATE OF INSURANCE COVERAGE