Pre-Admission Testing/Patient Registration Information

PLEASE PRINT CLEARLY • TODAY'S DATE

(OB Patients Only) What was the date of your last menstrual period?_____ Date of your procedure/delivery/service? _____ Doctor's Name: _____

Patient Name: _____ (Last / First / M.I.)
Address: _____
City, State, Zip: _____
Phone#: (____) _____
Date of Birth: _____ Male: _____ Female: _____
Social Security #: _____
State you were born in? _____ Drivers Lic #: _____
Marital Status (circle one): M • S • W • D • Other _____
Maiden Name (If Applicable): _____
Employer Name: _____
Occupation: _____
Address: _____
City, State, Zip: _____
Phone#: (____) _____ Cell: (____) _____
Do you work (circle one): _____
F/T • P/T • Self Emp. • Student • Active Duty • Homemaker
Retired: Yes ___ No ___ If yes, what year: _____

Spouse/Partner Name: _____ (Last / First / M.I.)
Address: _____
City, State, Zip: _____
Phone#: (____) _____
Date of Birth: _____ Male: _____ Female: _____
Social Security #: _____
Employer Name: _____
Occupation: _____
Maiden Name (If Applicable): _____
Address: _____
City, State, Zip: _____
Phone#: (____) _____ Cell: (____) _____
Do you work (circle one): _____
F/T • P/T • Self Emp. • Student • Active Duty • Homemaker
Retired: Yes ___ No ___ If yes, what year: _____

Please list someone you would use for an Emergency Contact (Please use someone other than your spouse):

Name: _____
Address: _____
Daytime Phone #: (____) _____
Relationship to you: _____
City, State, Zip: _____
Work Phone # (if any): (____) _____

The California Office of Statewide Planning and Development requires **ALL** hospitals report statistical data with regard to race and ethnicity. This information is **confidential** and does not affect or determine your medical services. Please circle only one for Ethnicity and only one for Race:

Race: Hispanic Non-Hispanic

Ethnicity: Caucasian/White African American/Black Asian/Pacific Islander Native American/Eskimo/Aleut OTHER

Do you have a religious preference? If so, please list: _____

Advance Directive: Do you have anything in writing that states who would make the medical decisions for you if you were unable?
Circle One: YES or NO If yes, check all that apply: ❑ Durable Power of Attorney for Health Care ❑ Living Will ❑ Directive to Physicians
If you have any of the above listed, please bring a copy to the hospital to put on file for future services. If you already have one on file, please list approximate date you submitted it to our facility. Date submitted: _____

Insurance Information: (Please Circle One): HMO • PPO • EPO • POS • Self Pay • Active Duty • Medicare • Medical
Name of Insurance: _____
ID #: _____ Group #: _____ Plan #: _____
If HMO, what medical group do you belong to: _____
If HMO, who is your PCP: _____
Who is the subscriber for insurance: _____
Relationship (circle one): Self • Spouse • Parent • Other _____
Social Security #: _____ Date of Birth: _____
If you have secondary insurance, please list: _____

For Any Questions, please call the Patient Access Department: (951) 788-3331

4445 Magnolia Avenue • Riverside, CA • 92501
Main Hospital: 951.788.3000
www.riversidecommunityhospital.com

RIVERSIDE Community Hospital