

# 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: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_  
Last First M.I. Last First M.I.

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

State you were born in? \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Marital Status (circle one): M • S • W • D • Other \_\_\_\_\_ Occupation: \_\_\_\_\_

Maiden Name (If Applicable): \_\_\_\_\_ Maiden Name (If Applicable): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Do you work (circle one): \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ F/T • P/T • Self Emp. • Student • Active Duty • Homemaker

Do you work (circle one): \_\_\_\_\_ Retired: Yes \_\_\_ No \_\_\_ If yes, what year: \_\_\_\_\_

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: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Daytime Phone #: (\_\_\_\_) \_\_\_\_\_ 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

