PROVIDENCE
Saint John's
Health Center

Reset Form

PROVIDENCE SAINT JOHN'S HEALTH CENTER
MATERNITY PRE-ADMISSION FORM

Your Physician's Name _____

Is this a scheduled cesarean section? ☐ Yes ☐ No

Estimated Date of Admission or Due Date _____ Last Menstrual Period _____

Have you been a patient at Saint John's before? ☐ Yes ☐ No

When? _____ Under What Name? _____

Have you completed a Durable Power of Attorney for Health Care? ☐ Yes ☐ No

PATIENT INFORMATION

Legal Last Name _____ First Name _____ MI _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Street Address _____ City _____ State _____ Zip Code _____

Telephone 1 _____ Telephone 2 _____ Email _____

Social Security Number _____ Driver's License or ID Number _____ Mother's Maiden Name _____

Religion / Religious Preference _____ State or Country of Birth _____

PATIENT EMPLOYMENT INFORMATION

Employer Name _____ Street Address _____ City _____

State _____ Zip Code _____ Telephone _____ Occupation _____

SPOUSE / SIGNIFICANT OTHER INFORMATION

Name _____ Street Address _____ City _____

State _____ Zip Code _____ Telephone 1 _____ Telephone 2 _____

Relationship to Patient _____

EMERGENCY CONTACT INFORMATION

Name _____ Street Address _____ City _____

State _____ Zip Code _____ Telephone 1 _____ Telephone 2 _____

Relationship to Patient _____

INSURANCE POLICY HOLDER

Name _____ Date of Birth _____

Relationship to Patient _____ Driver's License or ID Number _____

Billing Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Employer Name _____ Employer Address _____

City _____ State _____ Zip Code _____

Employer Telephone _____ Occupation _____

Social Security Number _____

PRIMARY INSURANCE

Name of Insurance Company or Administrator _____

Claims Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Policy Number _____ Group Number _____

Insured's Relationship to Patient _____

Do you have a: ☐ HMO ☐ PPO

SECONDARY INSURANCE

Name of Insurance Company or Administrator _____

Claims Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Policy Number _____ Group Number _____

Social Security Number _____ Date of Birth _____

I certify that the above is correct and accurate to the best of my knowledge.

Patient signature _____ Date _____

Patient representative signature _____ Date _____

Please email or mail completed form, a copy of a picture ID and copies of insurance cards (front and back) to:

Providence Saint John's Health Center Admitting Office
Central Access Services/Providence Portland Medical Center
P.O. Box 3335, Portland, OR 97208-9796

Email Address; ORWebRegister@providence.org

For verification of registration or questions, call 503-215-9579 or 503-215-9592.

Note: *The uninsured portion of your account is due prior to discharge (deductible, co-pay and co-insurance). Any questions regarding payment should be directed to the Financial Counseling Department at 310-582-7270.*

Federal law requires the Health Center to ask all patients if they have completed an **Advanced Directive Form** and to provide information about their rights to make health care decisions. If you have completed an **Advanced Directive Form**, please bring a copy when you are admitted to the hospital.