Maternal Child Health
Community Memorial Health System

PRE-REGISTRATION

Community Memorial Hospital is pleased to offer our patients a pre-registration service that allows us to verify all demographic and insurance information prior to your delivery. Expectant mothers should pre-register by the seventh month of pregnancy and complete the pre-admission form at the back of this brochure. The pre-registrationprocess allows CMH to communicate with your insurance company to verify benefits and eligibility, start pre-certification, and obtain pre-authorization beforehand, so you can plan accordingly.

When you complete the form on the other side of this document please, bring it to the Admitting Department at Community Memorial Hospital.

147 N. Brent St., Ventura, CA
Monday - Friday 8:00 a.m. - 7:00 p.m.

Pre-Registration can also be completed at the conclusion of the Maternity Tours.

ADVANTAGES OF PRE-REGISTRATION:
- Eliminates the stress of doing paperwork while you're in labor or in the hospital.
- Eliminates discharge delays by allowing you to pay co-pays and co-insurance before you are admitted.

HAVE THE FOLLOWING INFORMATION READY:
- Identification that includes your photograph and signature (such as your driver's license).
- Name of the Pediatrician/Family Practice Physician who will care for your infant.
- Insurance company information/card.
- Name of your employer.
- Admitting date/due date.
- Social Security Number.
- Emergency notification numbers.

For any questions on how to pre-register, please call 805/667-2845 and ask for the Admitting Department.

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OB/GYN PRE-REGISTRATION FORM

Due Date: _____ Center for Family Health: _____
OB/GYN Doctor: _____ Pediatrician: _____
Last Menstrual Period: _____ Primary Care Physician: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Maiden Name: _____ Date of Birth: _____ Sex: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Other Phone: _____ SSN: _____
Marital Status: _____ Religion: _____ Race: _____

PATIENT EMPLOYER

Company: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone: _____ Occupation: _____
Status: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Disabled ☐ Unemployed

SUBSCRIBER TO INSURANCE

Name: _____ Date of Birth: _____ U.S. Citizen: ☐ Yes ☐ No
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ SSN: _____ Relation to Patient: _____
Employer: _____ Occupation: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone: _____
Status: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Disabled ☐ Unemployed

INSURANCE INFORMATION

Primary Insurance Name: _____
Policy #: _____ Group#: _____ Phone: _____
Secondary Insurance Name: _____
Policy #: _____ Group#: _____ Phone: _____

NEXT OF KIN

Name: _____ Relationship to Patient: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Other Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Other Phone: _____