



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 <input type="checkbox"/> Hispanic / Latino—Other <input type="checkbox"/> Non-Hispanic / Non-Latino		Marital Status <input type="checkbox"/> Common Law <input type="checkbox"/> Married <input type="checkbox"/> Single / Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> Other		
	During your admission, we have your permission to disclose <i>(check all applicable boxes):</i>		<input type="checkbox"/> Name <input type="checkbox"/> Condition <input type="checkbox"/> Location / Phone	<input type="checkbox"/> Religion <input type="checkbox"/> No Information / Confidential Admit	Clergy visit? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Race <input type="checkbox"/> Asian / Pacific Islander—Other Asian <input type="checkbox"/> Native American / Eskimo / Aleutian—Other <input type="checkbox"/> Asian / Pacific Islander—Other Pacific Islander <input type="checkbox"/> White—Other White or European <input type="checkbox"/> Black—Other Black <input type="checkbox"/> Other <input type="checkbox"/> 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
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ADDRESS	CITY	STATE	ZIP
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<input type="checkbox"/> Male	DATE OF BIRTH	HOME PHONE
<input type="checkbox"/> Female		

EMPLOYER	EMPLOYMENT STATUS
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EMPLOYER ADDRESS	CITY	STATE	ZIP
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OCCUPATION	WORK PHONE
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Other Insurance Information

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT
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ADDRESS	CITY	STATE	ZIP
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<input type="checkbox"/> Male	DATE OF BIRTH	HOME PHONE
<input type="checkbox"/> Female		

SUSCRIBER EMPLOYER	EMPLOYMENT STATUS
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EMPLOYER ADDRESS	CITY	STATE	ZIP
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OCCUPATION	WORK PHONE
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MEDICARE CLAIM NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
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MEDI-CAL BENEFITS ID NO.	MEDI-CAL ISSUE DATE
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OTHER INSURANCE COMPANY	GROUP NO.	INSURANCE ID
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INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP
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INSURANCE PHONE	EFFECTIVE DATE OF INSURANCE COVERAGE
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