Castle Medical Center -Adventist Health

## Pre-Admission

To make your admission easier, please complete this form as soon as possible, at least 3 weeks prior to your due date. To make financial arrangements for the portion of your bill not covered by insurance, please call 263-5130. For other information, call the Information and Referral Service at 263-5400.

Due Date:	Last Menstrual Perio	od:		
Your OB Provider's Name:		Previous adn	nission at CM	C? Yes / No
Your Baby's Doctor's Name:		MRN (hospital use only)		
PATIENT INFORMATION:				
Patient's Full Name: Last _	First	Middle	S	S#
Street Address			PI	hone
Age BirthDate/_	/Birthplace	Marital Status <u>M/</u>	<u>S/D/W</u> Maide	n Name
Religious preference		optional) BLK WHT CHI FIL HA	W JPN SAM TONG	VIET OTHER
Employed by	Occupation	Military status	? Active Duty	/ Reserve / Veteran
Employer address		Bus Phone	9	_
Primary Care Physician		Phone		
Preferred Spoken Languag	ge	_ Preferred Written	Language	
CONTACT PERSON (Hus	band, Baby's Father,	Parent, etc)		
Full Name: Last	First	Middle	SS#	
Street Address				Phone
AgeBirthDate/	/Birthplace	Marital Status	<u>M/S/D/W</u>	
Religious preference		optional) BLK CAU CHI FIL HA	W JAP SAM TONG	VIET OTHER
Employed by	Occupation			
Employer address		Bus Phor	1e	
INSURANCE: (Please bring your	r Insurance cards and Identifica	tion cards upon admission)		
Primary Insurance Co	_Membership No	Medical Coverag	ge Code	Subscriber
Insurance Company Addre	ess			
Secondary Insurance Co_				
Insurance Company Addre	ess			

When complete, you may turn in to your provider, or mail directly to Castle Medical Center, Attn: Registration, 640 Ulukahiki Street, Kailua, HI 96734. You may also fax it to us at 808-263-5409