Pre-Admission Form

This form, will provide us with information to begin your medical record and to verify your insurance.
Please complete the form and return it by mail or fax 626-821-6968 to the admitting department as soon as possible prior to your scheduled arrival date.

PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME Last First MI Date of Birth Age Sex

SSN Race Marital Status Mother's Maiden Name Driver's License No. Birthplace

PATIENT ADDRESS City State Zip Code

Home / Cell Phone Work Phone Email

Race Religion Primary Language

Employer Occupation Employer's Address City State Zip Code Length of Employment

EMERGENCY CONTACT Relation to Patient Address (if different from above) City State Zip Code

Home / Cell Phone Work Phone

INSURANCE INFORMATION (PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD)

PRIMARY INSURANCE Address City State Zip Code Phone

Subscriber Name Date of Birth ID / Social Security No. Group No. Primary Physician Name Effective Date

SECONDARY INSURANCE Address City State Zip Code Phone

Subscriber Name Date of Birth ID / Social Security No. Group No. Primary Physician Name Effective Date

ADDITIONAL INFORMATION (FOR OBSTETRICAL PATIENTS ONLY)

Attending Physician

Obstetrical Patient Due Date

USC Arcadia Hospital
Keck Medicine of USC
300 W. Huntington Drive, Arcadia, CA 91007

Obstetrical patients: Please complete the form and return it to the hospital admitting department soon after the end of your fifth month of pregnancy.
BRING A COPY OF ANY POWER OF ATTORNEY OR ADVANCED DIRECTIVES TO THE ADMITTING DEPARTMENT AT THE TIME OF ADMISSION.