OBGYN WESTSIDE, PLLC

Information for Maternity Pre-Admission

The Mount Sinai Medical Center Maternity Pre-Admission Questionnaire.

The attached form is used by the Financial Screening Department of Mount Sinai to register you into their system so they are prepared for you at the time of your delivery.

Please fill out the form to the best of your ability and mail or fax it to the Financial Screening Department.

ADDRESS: Mount Sinai Medical Center
ATTN: Financial Screening
One Gustave L. Levy Place, BOX 650
New York, NY 10029-9988

FAX: 212-822-4950

The phone number for Patient Financial Services is 212-731-3800

If you have any questions.

Please visit Mount Sinai's website for additional information:

http://www.mountsinai.org/patient-care/service-areas/obgyn-and-reproductive-services/areas-of-care/pregnancy-and-birth

Thank you!

THE MOUNT SINAI MEDICAL CENTER
ONE GUSTAVE L. LEVY PLACE, BOX 6500
NEW YORK, NEW YORK 10029

MATERNITY PRE-ADMISSION QUESTIONNAIRE

TO ENSURE AN EXPEDIENT ADMISSION AND AN ACCURATE BIRTH CERTIFICATE PLEASE RETURN QUESTIONNAIRE WITHIN 10 DAYS OF RECEIPT. UPON RECEIPT OF THIS FORM, WE WILL SEND YOU AN INFORMATION PACKET.

Estimated Date of Admission _____ Referred By: ☐ Mount Sinai Hospital Physician ☐ E-Level

Obstetrician _____ ☐ Settlement ☐ Boriken ☐ Other _____

Please indicate the last name which will be used to identify you and your baby throughout hospitalization.

PATIENT'S NAME LAST FIRST MIDDLE MAIDEN

HOME ADDRESS STREET APT NO. AREA CODE / TEL. NO

CITY / TOWN COUNTY STATE ZIP CODE SOCIAL SECURITY

MAILING ADDRESS (IF DIFFERENT FROM HOME) AREA CODE / TEL NO.

MATERNITY PATIENT INFORMATION

AGE BIRTH DATE BIRTH PLACE RELIGION RACE ANCESTRY

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

MOTHER'S FULL NAME _____

FATHER'S FULL NAME _____

NEXT OF KIN NAME RELATIONSHIP ADDRESS AREA CODE / TEL NO.

NOTIFY IN EMERGENCY NAME RELATIONSHIP ADDRESS AREA CODE / TEL NO.

MOST RECENT CARE

WERE YOU EVER HOSPITALIZED AT MOUNT SINAI? ☐ YES **IF YES**: MEDICAL RECORD NO. _____

☐ NO ☐ E-LEVEL ☐ ER ☐ HOSPITAL ☐ OTHER _____

UNDER WHAT LAST NAME WERE YOU REGISTERED IF DIFFERENT FROM ABOVE? _____

PATIENT'S OCCUPATION

EMPLOYER _____ ADDRESS _____

OCCUPATION _____ DAYTIME AREA CODE / TEL NO. _____

ARE YOU A CURRENT MOUNT SINAI HOSPITAL EMPLOYEE? ☐ YES NO ☐

☐ **SPOUSE'S OR** ☐ **PARENT'S OCCUPATION**

PLEASE CHECK ONE

EMPLOYER _____ ADDRESS _____

OCCUPATION _____ HOW LONG? _____ ADDRESS _____

SOCIAL SECURITY NO. _____ DAYTIME AREA CODE / TEL NO. _____

ARE YOU A CURRENT MOUNT SINAI HOSPITAL EMPLOYEE? ☐ YES ☐ NO

INSURANCE:

PRIMARY INSURANCE FC:

INSURANCE CO. NAME _____ TEL NO. TO VERIFY ELIGIBILITY _____

EFFECTIVE DATE _____ ADDRESS _____ CITY _____

STATE _____ ZIP _____ POLICY HOLDER'S NAME _____

PATIENT RELATIONSHIP TO INSURED: SELF CERTIFICATE / GROUP ID # _____

☐ SPOUSE ☐ OTHER ☐ CHILD

SECONDARY INSURANCE FC:

INSURANCE CO. NAME _____ TEL NO. TO VERIFY ELIGIBILITY _____

EFFECTIVE DATE _____ ADDRESS _____ CITY _____

STATE _____ ZIP _____ POLICY HOLDER'S NAME _____

PATIENT RELATIONSHIP TO INSURED: SELF CERTIFICATE / GROUP ID # _____

☐ SPOUSE ☐ OTHER ☐ CHILD

OTHER INFORMATION

TO BE COMPLETED BY FATHER OF CHILD:

FULL NAME _____ BIRTH DATE _____