THE MOUNT SINAI MEDICAL CENTER
ONE GUSTAVE L. LEVY PLACE
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. | BIRTH DATE

NOTIFY IN EMERGENCY

NAME | RELATIONSHIP | ADDRESS | AREA CODE / TEL NO. | BIRTH DATE

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 ______________________ 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. ______________________ 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 ______________________ BIRTH DATE ______________________

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 ______________________ BIRTH DATE ______________________

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

☐ SPOUSE ☐ OTHER ☐ CHILD

OTHER INFORMATION

<u>TO BE COMPLETED BY FATHER OF CHILD:</u>

FULL NAME ______________________ BIRTH DATE ______________________