



Bakersfield Memorial Hospital

CHW

420 34<sup>th</sup> Street  
Bakersfield, CA 93301

# PREADMISSION REGISTRATION

PHONE: (661) 327-4647 ext. 4852  
FAX: (661) 861-9058  
HOURS: 9:00 am to 4:00 pm

ADDRESSOGRAPH

PLEASE COMPLETE AND RETURN

FOR OFFICE USE ONLY:  SDC  AM  IN

Expected date of admission: \_\_\_\_/\_\_\_\_/\_\_\_\_

Maternity Expected date of delivery: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Patient's name: \_\_\_\_\_  
Last First Middle

Age: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last menstrual period: \_\_\_\_\_

Maiden / other name: \_\_\_\_\_ Mother's first name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Home phone #: (\_\_\_\_) \_\_\_\_\_ Social security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  Male  Female Smoke:  Yes  No Object:  Yes  No

Religion: \_\_\_\_\_ Affiliation: \_\_\_\_\_ Race: \_\_\_\_\_

Marital status:  Single  Married  Separated  Widowed  Divorced

Patient's employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Work phone #: (\_\_\_\_) \_\_\_\_\_ Patient here before?  Yes  No

## NEXT OF KIN / SPOUSE

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Home phone #: (\_\_\_\_) \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Work phone #: (\_\_\_\_) \_\_\_\_\_ Social security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PERSON TO NOTIFY (someone other than spouse / next of kin)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ Home phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Insurance #1: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance #2: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance #3: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_

Admitting physician: \_\_\_\_\_ Family physician: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Procedure: \_\_\_\_\_

FOR OFFICE USE ONLY: Empl / Verified:  Yes  No