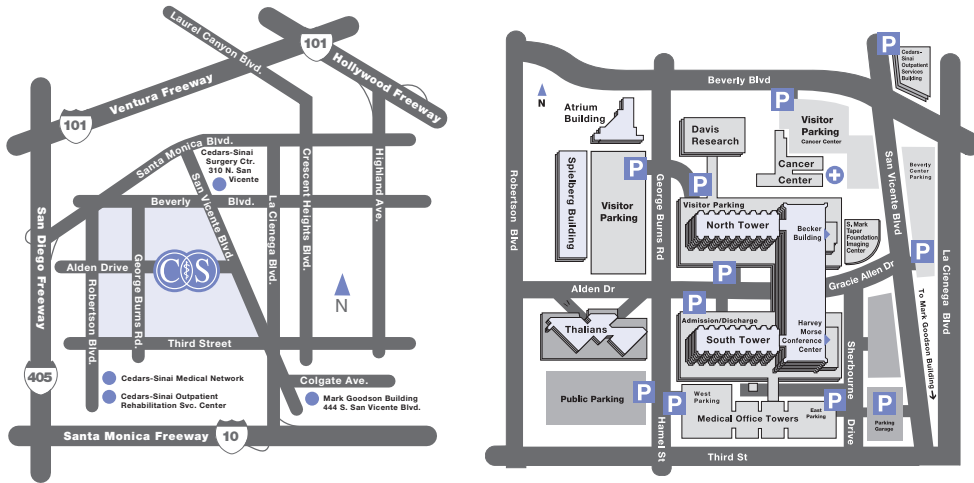


**INFORMATION:** If you have any question, please call (310) 423-3798.

**MATERNITY TOUR:** Expectant parents are invited to take a complimentary tour of our Maternity Center. The tour is a wonderful opportunity to become acquainted with our facility and services as well as to meet our Medical Center Staff. A telephone reservation is required. Private tours are available. Call (310) 423-5168.

**EDUCATION PROGRAMS:** For information on our education programs call (310) 423-5168  
Pre-Admission and financial questions, please call: (909) 879-7820



Cedars-Sinai Medical Center's campus is located at 8700 Beverly Boulevard in Los Angeles. It is bordered to the east by San Vicente Boulevard, to the south by Third Street and to the west by Robertson Boulevard.

**FROM THE SANTA MONICA FREEWAY (10),** Exit at La Cienega Boulevard. Proceed north to the Medical Center, just north of Third Street. **FROM THE HOLLYWOOD FREEWAY (101),** Exit at Highland Avenue. Proceed south to Beverly Boulevard. Turn right and proceed to the Medical Center at San Vicente Boulevard. Turn left.

**PLEASE FOLD THIS APPLICATION FORM IN HALF, STAPLE AND DROP IN A MAILBOX.**

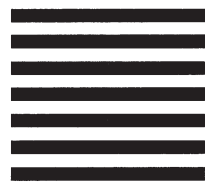
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8700 Beverly Blvd., Room 3409  
Los Angeles, CA 90048



C E D A R S - S I N A I

*P*re-Admission  
*F*orm

**PLEASE PRINT AND COMPLETE IN FULL  
PLEASE FOLD THIS PRE-ADMISSION FORM  
IN HALF, STAPLE AND DROP IN A MAILBOX  
OR YOU MAY FAX TO: (310) 423-0104**

**PATIENT INFORMATION**

Legal Name ..... Birthdate .....  
Religious Preference ..... Birthplace .....  
Social Security Number ..... Calif. Driver's License or ID .....  
Marital status:  Married  Single  Divorced  Widow  Separated  
Ethnicity:  Hispanic  Non-Hispanic Language:  English  Other: .....  
Interpreter Needed?  Yes  No  
Race:  Caucasian  Black  Asian/Pacific Islander  Native American/Eskimo/Aleut  Other  
Maiden Name ..... Mother's Maiden Name .....  
Street Address ..... Apt. ....  
City ..... State ..... Zip .....  
Telephone ..... Cell ..... E-mail .....  
Estimated Date of Delivery ..... Last Menstrual Period .....  
Your Obstetrician's Name .....  
Have you been a patient at this hospital before  Yes  No If yes, when  
Under what name(s)? .....

**PATIENT EMPLOYMENT INFORMATION**

Occupation ..... Employer Name .....  
Employer Street Address ..... City .....  
State ..... Zip .....  
Telephone ..... Cell ..... E-mail .....

**SPOUSE/PARTNER INFORMATION**

Name ..... Social Security Number .....  
Birthdate ..... Ethnicity:  Hispanic  Non-Hispanic  
Race:  Caucasian  Black  Asian/Pacific Islander  Native American/Eskimo/Aleut  Other  
Occupation ..... Employer Name .....  
Employer Street Address ..... City .....  
State ..... Zip .....  
Telephone ..... Cell ..... E-mail .....

**Paternity Declaration** *A new California law requires that unmarried fathers sign a Declaration of Paternity if they wish their names to appear on birth certificates. The declaration may be signed while the child is in the hospital and turned in with the birth certificate worksheet. If it is signed after the child is discharged from the hospital, the father must pay a fee to have the birth certificate amended. Our Birth Records department will provide informational materials, as well as the declaration form.*

**EMERGENCY NOTIFICATION**

Name ..... Relationship to Patient .....  
Street Address ..... Apt.....  
City ..... State ..... Zip .....  
Telephone (day) ..... (evening) .....

**2ND EMERGENCY CONTACT (NOT LIVING AT HOME)**

Name ..... Relationship to Patient .....  
Street Address ..... Apt.....  
City ..... State ..... Zip .....  
Telephone (day) ..... (evening) .....

**INSURANCE INFORMATION**

Name of Insurance Company or Administrator .....  
Address ..... City .....  
State ..... Zip ..... Telephone .....

Name of Insured Person ..... Relationship to Patient .....  
Insured's Social Security No. .... Policy Group No. ....

Is an authorization for treatment required by your health plan?  Yes  No  
Effective date ..... Annual deductible ..... % Coverage .....

Secondary Insurance Company or Administrator if any .....  
Address ..... City .....  
State ..... Zip ..... Telephone .....

Name of Insured Person ..... Relationship to Patient .....  
Insured's Social Security No. .... Policy Group No. ....

Is an authorization for treatment required by your health plan?  Yes  No  
Effective date ..... Annual deductible ..... % Coverage .....

**For all patients, a copy of your legal photo I.D. is required.**

**For all insured patients, a copy of your current insurance card (front and back) is required.**

**I certify that the above information is correct and accurate to the best of my knowledge.**

.....  
*Patient Signature* *Date* *Patient Representative Signature* *Date*

**If you would like to receive an acknowledgment that Cedars-Sinai Medical Center received your Pre-Admissions form, please sign below:**

.....  
*Patient Signature* *Date*