Castle Medical Center
Adventist Health

Pre-Admission

To make your admission easier, please complete this form as soon as possible, at least 3 weeks prior to your due date. To make financial arrangements for the portion of your bill not covered by insurance, please call 263-5130. For other information, call the Information and Referral Service at 263-5400.

Due Date:___________ Last Menstrual Period: __________

Your OB Provider's Name: _____________________ Previous admission at CMC? Yes / No

Your Baby's Doctor's Name: _____________________ MRN (hospital use only) ______________

PATIENT INFORMATION:

Patient's Full Name: Last __________ First __________ Middle __________ SS#__________

Street Address ____ Phone __________

Age ____ BirthDate ___/____/___Birthplace ____ Marital Status M/S/D/W Maiden Name _________

Religious preference __________ Race (optional) BLK WHT CHI FIL HAW JPN SAM TONG VIET OTHER _________

Employed by __________ Occupation __________ Military status? Active Duty / Reserve / Veteran

Employer address ______________________________ Bus Phone __________

Primary Care Physician ____________________ Phone __________

Preferred Spoken Language ________________ Preferred Written Language ________________

CONTACT PERSON (Husband, Baby's Father, Parent, etc)

Full Name: Last __________ First __________ Middle __________ SS#__________

Street Address __________ __________ __________ __________ __________ Phone __________

Age ____BirthDate ___/____/___ Birthplace _______ Marital Status M/S/D/W

Religious preference __________ Race (optional) BLK CAU CHI FIL HAW JAP SAM TONG VIET OTHER _________

Employed by __________ Occupation __________

Employer address __________ __________ __________ Bus Phone __________

INSURANCE: (Please bring your Insurance cards and Identification cards upon admission)

Primary Insurance Co ____Membership No. _____ Medical Coverage Code _____ Subscriber____

Insurance Company Address ________ __________ __________ __________ ____________

Secondary Insurance Co ____Membership No. ____ Medical Coverage Code _____ Subscriber____

Insurance Company Address ____

When complete, you may turn in to your provider, or mail directly to Castle Medical Center, Attn: Registration, 640 Ulukahiki Street, Kailua, HI 96734. You may also fax it to us at 808-263-5409