The Mount Sinai Medical Center
One Gustave L. Levy Place
Box 1497 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 ☐ Borlken ☐ 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**
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

TO BE COMPLETED BY FATHER OF CHILD:

FULL NAME _____ BIRTH DATE _____