Good Samaritan Hospital/Mission Oaks Hospital
San Jose, California

OBSTETRICAL ADMISSION INFORMATION

LAST MENSTRUAL PERIOD	EXPT. DUE DATE

PHYSICIAN / OBSTETRICIAN	PEDIATRICIAN	PRIMARY CARE PHYSICIAN

PATIENT NAME (Please Print) LAST	FIRST	MIDDLE INITIAL	MAIDEN OR PREVIOUS NAME(S)

PATIENT ADDRESS STREET	(APT#)	CITY	STATE	ZIP	PHONE (Area Code)

MARITAL STATUS: (Circle One) ○SIN ○MAR ○DIV ○WID ○SEP	RELIGION	BIRTHDATE MO DAY YR	SOC. SEC.#

EMPLOYER	EMPLOYER ADDRESS	PATIENT'S OCCUPATION

CITY	STATE	ZIP	PHONE

Spouse / Significant Other Information

NAME OF SPOUSE / SIGNIFICANT OTHER	SPOUSE BIRTHDATE MO DAY YR

SPOUSE EMPLOYER	EMPLOYER ADDRESS

CITY	STATE	ZIP	PHONE	SOC. SEC # OF SPOUSE

Alternate Emergency Contact

NAME	RELATION TO PATIENT	WORK PHONE	HOME PHONE

ADDRESS	CITY	STATE	ZIP

THE FOLLOWING SECTIONS APPLY TO THE FINANCIAL RESPONSIBILITY FOR THIS HOSPITAL STAY.
SECTION 1. IN ORDER TO BILL YOUR INSURANCE COMPANY (CARRIER), WE WILL NEED THE FOLLOWING INFORMATION:

PRIMARY INSURANCE ☐ HMO ☐ PPO Out of State / Area ☐ _____		SECONDARY INSURANCE ☐ HMO ☐ PPO Out of State / Area ☐ _____	
1) Subscriber Name		**1) Subscriber Name**	
2) Subscriber SS#		**2) Subscriber SS#**	
3) Subscriber D.O.B.		**3) Subscriber D.O.B.**	
4) ID/Policy #		**4) ID/Policy #**	
5) Relationship to Patient		**5) Relationship to Patient**	
6) Name of Insurance Co		**6) Name of Insurance Co**	
7) Address		**7) Address**	
8) City, State, Zip		**8) City, State, Zip**	
9) Name of Medical Group		**9) Name of Medical Group**	
10) Group Name		**10) Group Name**	
11) Group #		**11) Group #**	
12) Union Local		**12) Union Local**	
13) Ins. Phone#		**13) Ins. Phone#**	

RELEASE OF DIAGNOSIS: I here by authorize The Good Samaritan Hospital to release my diagnosis to my insurance carriers and/or employer for the purpose of insurance verification.

DATE SIGNATURE OF PATIENT

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to The Good Samaritan Hospital, the hospital benefits otherwise payable to me for the hospitalization of this patient. I understand that I am financially responsible to the hospital for the charges not covered by my group insurance plan.

DATE_____ SIGNED_____
(NAME OF PERSON INSURED)