VIRGINIA HOSPITAL CENTER

Send to: Virginia Hospital Center
ATTN: Admissions Department
1701 North George Mason Drive
Arlington, VA 22205

PRE-ADMISSION QUESTIONNAIRE

DATE OF LAST MENSTRUAL, PERIOD

OBSTETRICIAN NAME

ESTIMATED DATE OF DELIVERY

PLEASE PRINT OR TYPE ALL INFORMATION

PATIENT INFORMATION

PATIENT (LAST) (FIRST) (MI)

SOCIAL SECURITY NUMBER

PRIMARY CARE PHYSICIAN

ADDRESS (STREET AND NUMBER) APT. NO.

DIABETIC: ☐ YES ☐ NO
ALLERGIES: ☐ YES ☐ NO (IF "YES" WHAT TYPE:_____)

CITY | STATE | ZIP

EMPLOYEE NAME

HOME PHONE #

MAIDEN NAME

WORK ADDRESS (STREET AND NUMBER)

PLACE OF BIRTH | DATE OF BIRTH | PATIENT EMAIL

CITY | STATE | ZIP

RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ ASIAN
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ PACIFIC ISLANDER ☐ OTHER_____

WORK PHONE # | OCCUPATION

MARITAL STATUS: ☐ MARRIED ☐ SINGLE

RELIGION

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ YES ☐ NO
IF "YES" PLEASE ATTACH TO PRE-REGISTRATION FORM

SPOUSE / PARENT

SPOUSE/PARENT (LAST) (FIRST) (MI)

PLACE OF BIRTH | DATE OF BIRTH

EMPLOYEE NAME | WORK ADDRESS (STREET AND NUMBER) | CITY | STATE | ZIP

WORK PHONE # | OCCUPATION

EMERGENCY CONTACT

RELATION TO PATIENT | PATIENT (LAST) (FIRST) (MI)

ADDRESS (STREET AND NUMBER) | APT. NO. | CITY | STATE | ZIP | HOME PHONE #

RESPONSIBLE PARTY

☐ SAME AS SPOUSE ☐ SAME AS PATIENT ☐ SAME AS EMERGENCY CONTACT ☐ OTHER (COMPLETE INFO BELOW)

NAME (LAST) (FIRST) (MI) | SOCIAL SECURITY NUMBER | DATE OF BIRTH

EMPLOYEE NAME | WORK ADDRESS (STREET AND NUMBER) | CITY | STATE | ZIP

WORK PHONE # | OCCUPATION | RELATIONSHIP TO PATIENT

PRIMARY INSURANCE INFORMATION

☐ NO HEALTH PLAN (SELF PAY) | NAME OF INSURANCE | TYPE OF INSURANCE (HMO, PPO, ETC.)

INSURANCE ADDRESS (STREET AND NUMBER) | CITY | STATE | ZIP | HOME PHONE #

POLICY # | GROUP # | POLICY HOLDER NAME | POLICY HOLDER DOB | POLICY HOLDER EMPLOYER | RELATIONSHIP TO PATIENT

SECONDARY INSURANCE INFORMATION

☐ NO HEALTH PLAN (SELF PAY) | NAME OF INSURANCE | TYPE OF INSURANCE (HMO, PPO, ETC.)

INSURANCE ADDRESS (STREET AND NUMBER) | CITY | STATE | ZIP | HOME PHONE #

POLICY # | GROUP # | POLICY HOLDER NAME | POLICY HOLDER DOB | POLICY HOLDER EMPLOYER | RELATIONSHIP TO PATIENT

MATERNITY PRE-REGISTRATION

ONCE YOUR BABY IS BORN, HE/SHE WILL BE PLACED ON YOUR: ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE
☐ WILL BE SELF PAY ☐ THE BABY WILL BE PLACED ON A COMPLETELY SEPARATE POLICY (FILL IN ALL INFO BELOW)

NAME OF INSURANCE | TYPE OF INSURANCE (HMO, PPO, ETC.)

INSURANCE ADDRESS (STREET AND NUMBER) | CITY | STATE | ZIP | HOME PHONE #

POLICY # | GROUP # | POLICY HOLDER NAME | POLICY HOLDER DOB | POLICY HOLDER EMPLOYER | RELATIONSHIP TO PATIENT