THE MOUNT SINAI MEDICAL CENTER
ONE GUSTAVE L. LEVY PLACE
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 ☐ Boriken ☐ 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'S 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 ______________