Welcome to Saddleback Women’s Hospital. You have chosen one of the most comprehensive birth centers in Southern California to have your baby. It is our goal to provide a warm, friendly place where your needs for comfort and caring will be met.

For your convenience, any necessary paperwork and insurance verification can be completed well in advance of the day of your delivery. Your preadmission packet includes the following material:

1. **Patient Guide.** Please read this important guide, which includes patients’ rights, advanced directives, and other information you will need to know about your hospital stay.

2. **Preadmission Form.** Please read and complete the form. If you have a MemorialCare Card complete front of page 2. If not, complete back side of page 2.

3. **Conditions of Admission Form.** Please read and sign both forms (one for the mother and one for the baby) where indicated. Terms and conditions of the agreement evidenced by this form are not binding until you receive care and treatment from the hospital.

4. **Financial Agreement.** Please read and sign where indicated.

5. **Commitment to Safety.** Please read and sign where indicated.


We have enclosed an envelope for you to mail the completed forms back to us. Be sure to include the completed Preadmission Form, the two signed Conditions of Admission Forms, Financial Agreement and front and back copies of your insurance cards.

Payment for services not covered by your insurance, including deductibles and estimated co-insurance payments, is due prior to or at time of discharge. You will be notified of the amount once your insurance coverage has been verified.

Check-in Location: 6 a.m. to 8 p.m., Saddleback Women’s Hospital Front Entrance 8 p.m. to 6 a.m., Main Hospital Emergency Services Entrance

What to Bring: You will need a few personal things such as toiletries, bathrobe, slippers, night clothes, infant clothes, receiving blanket, car seat, change for the vending machines, and your checkbook or credit card (Visa or Mastercard) to meet the prepayment requirements. For your safety, please leave all personal electrical items at home. These include hairdryer, curling irons, radios, etc.

Smoking: Saddleback Memorial Medical Center is a non-smoking facility.

Check-out Time: 11 a.m. or earlier.

Visiting Hours: General visiting hours are from 7 a.m. to 8 p.m., daily. Fathers have open visiting hours. Siblings and other immediate family can visit until 8 p.m., however they may not stay overnight. No other children (except for siblings) under the age of 16 are permitted.

If you have any questions concerning your admission, please contact Patient Access at (949) 452-3016, Monday through Friday, 8 a.m. to 5:30 p.m. We assure your birthing experience at Saddleback Women’s Hospital will be comfortable and pleasant. Thank you for choosing Saddleback Memorial Medical Center, a MemorialCare facility.
Obstetrical Preadmission Information

24451 Health Center Drive • Laguna Hills, CA 92653
949-452-3546

EXPECTED DUE DATE _______________ LAST MENSTRUAL PERIOD _______________ DOCTOR NAME _______________

PATIENT’S NAME (LAST, FIRST, MIDDLE) _______________ AKA, ALSO KNOWN AS (LAST, FIRST, MIDDLE) _______________

PATIENT’S ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________ HOME PHONE _______________

BIRTHDATE _______________ AGE _______________ MARITAL STATUS _______________ SOCIAL SECURITY NO. _______________ MAIDEN NAME _______________ RELIGION _______________

RACE: ☐ WHITE ☐ BLACK ☐ NATIVE AMERICAN ☐ ASIA/INDIA/PACIFIC ISLES ☐ ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC

INDICATE IF YOU HAVE A DURABLE POWER OF ATTORNEY (RIGHTS TO MAKE DECISIONS ABOUT MEDICAL TREATMENT)

DATE COMPLETED: _______________

EMPLOYER _______________
EMPLOYER’S ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________
EMPLOYER’S PHONE ( ) _______________ OCCUPATION _______________
EMPLOYMENT ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL-TIME STUDENT

SPOUSE’S OR OTHER RESPONSIBLE PARTY INFORMATION

NAME _______________ RELATIONSHIP _______________

ADDRESS (if different from patient’s) _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE ( ) _______________ SOCIAL SECURITY NUMBER _______________

EMPLOYER _______________
EMPLOYER’S ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________
EMPLOYER’S PHONE ( ) _______________ OCCUPATION _______________
EMPLOYMENT ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL-TIME STUDENT

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _______________

ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________
PHONE ( ) _______________ POLICY # _______________ GROUP # _______________
SUBSCRIBER NAME _______________ RELATIONSHIP _______________ BIRTHDATE _______________

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _______________

ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________
PHONE ( ) _______________ POLICY # _______________ GROUP # _______________
SUBSCRIBER NAME _______________ RELATIONSHIP _______________ BIRTHDATE _______________

NEWBORN INSURANCE INFORMATION

☐ SAME AS PRIMARY INSURANCE LISTED ABOVE ☐ SAME AS SECONDARY INSURANCE LISTED ABOVE

☐ OTHER INSURANCE NAME: _______________

ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________
PHONE ( ) _______________ POLICY # _______________ GROUP # _______________
SUBSCRIBER NAME _______________ RELATIONSHIP _______________ BIRTHDATE _______________

IN CASE OF EMERGENCY

GIVE NAME OF SPOUSE, PARENT, NEAREST RELATIVE OR FRIEND

FULL NAME _______________ RELATION _______________ AREA CODE _______________ HOME PHONE _______________ AREA CODE _______________ BUSINESS PHONE _______________

ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________

FULL NAME _______________ RELATION _______________ AREA CODE _______________ HOME PHONE _______________ AREA CODE _______________ BUSINESS PHONE _______________

ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

PATIENT’S DEDUCTIBLE AND ESTIMATED CO-INSURANCE IS DUE PRIOR TO ADMISSION OR AT TIME OF DISCHARGE. YOU WILL BE NOTIFIED OF THE AMOUNT ONCE YOUR INSURANCE COVERAGE HAS BEEN VERIFIED.

FOR CONVENIENCE, WE ACCEPT CASH, CHECKS, MASTERCARD AND VISA.
Complete This Side Only If You Have A MemorialCare Medical Information and Access Card...

PATIENT NAME ___________________________ MEMORIALCARE CARD ID # ___________________________

EXPECTED DUE DATE ________________ SOCIAL SECURITY # ________________ RELIGION ________________

RACE: ☐ WHITE ☐ BLACK ☐ NATIVE AMERICAN ☐ ASIA/INDIAN/PACIFIC ISLES ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC

DURABLE POWER OF ATTORNEY (RIGHTS TO MAKE DECISIONS ABOUT MEDICAL TREATMENT) DATE COMPLETED ________________

LAST MENSTRUAL PERIOD ________________ OB DOCTOR __________________________

YOUR EMPLOYER NAME ___________________________ OCCUPATION __________________________

ADDRESS ____________________________

                           city state zip

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL TIME STUDENT

SPOUSE OR OTHER RESPONSIBLE PARTY INFORMATION – ONLY IF DIFFERENT FROM PATIENTS:

NAME ___________________________ RELATIONSHIP __________________________

ADDRESS ____________________________

                           city state zip

EMPLOYER ____________________________ OCCUPATION __________________________

ADDRESS ____________________________

                           city state zip

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY ☐ NOT EMPLOYED ☐ FULL TIME STUDENT

NEWBORN INSURANCE INFORMATION:

☐ SAME AS PRIMARY INSURANCE LISTED FOR MOM ☐ SAME AS SECONDARY INSURANCE LISTED FOR MOM

☐ OTHER INSURANCE NAME ____________________________

ADDRESS ____________________________

                           city state zip

PHONE (   ) ____________________________ POLICY # ____________________________ GROUP # ____________________________

SUBSCRIBER NAME ___________________________ RELATIONSHIP __________________________ BIRTHDATE __________________________
Saddleback Memorial Medical Center (SMMC), a non-profit acute care facility, is dedicated to providing the very highest quality care and service to all of its patients.

The hospital will make every effort to ensure that you receive quality medical care which is medically necessary. However, please be aware that your health plan or designated medical group makes the final determination regarding your care.

SMMC will bill your insurance company for the healthcare services you receive at the hospital less any co-payment(s) or deductible(s). In the event that your insurance company denies payment for services as a result of, but not limited to, any reason or any reason listed below, you will be held financially responsible for the hospital charges incurred.

**Payment may be denied if your health plan or medical group determines:**
- the care given is not medically necessary
- the care given is a non-covered benefit
- the care given is non-emergent
- the recipient is ineligible to receive the insurance benefit
- any additional hospital days and/or service requested are not a medical necessity and only for convenience
- the care was not authorized

_I understand insurance authorization has not been obtained, and I wish to have services rendered regardless. Initial here (               )_

**Out-of-Network Financial Agreement**

I exercise my right to seek medical treatment without a referral from my Primary Care Physician/Medical Group. I understand that my Out-of-Network services have co-insurance charges, higher co-payments, and limited annual benefits. I also understand some Out-of-Network services such as hospitalization, outpatient surgeries, and cat-scans require pre-certification from my insurance company in order to receive full benefits. Initial here (               )

It is ultimately your responsibility to make sure that you obtain the necessary pre-authorization(s) from your health plan.

_I have read the preceding information and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. If my insurance company denies coverage and/or payment for services rendered to me at Saddleback Memorial Medical Center, I assume the financial responsibility._

Date ____________________ Time ____________________ Patient/Parent/Legal Representative ____________________

Witness ____________________ If signed by other than patient, indicate relationship ____________________