



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.					
CITY					STATE					
HOME PHONE #					MAIDEN NAME					
PLACE OF BIRTH			DATE OF BIRTH			PATIENT EMAIL			CITY	STATE
RACE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN					WORK PHONE #					OCCUPATION
<input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					DO YOU HAVE AN ADVANCED DIRECTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO					ZIP
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE					RELIGION					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)				
WORK PHONE #					OCCUPATION				

EMERGENCY CONTACT									
RELATION TO PATIENT			PATIENT (LAST) (FIRST) (MI)			DATE OF BIRTH			
ADDRESS (STREET AND NUMBER)					APT. NO.				
CITY					STATE				
HOME PHONE #					ZIP				

RESPONSIBLE PARTY									
<input type="checkbox"/> SAME AS SPOUSE <input type="checkbox"/> SAME AS PATIENT <input type="checkbox"/> SAME AS EMERGENCY CONTACT <input type="checkbox"/> OTHER (COMPLETE INFO BELOW)									
NAME (LAST) (FIRST) (MI)			SOCIAL SECURITY NUMBER			DATE OF BIRTH			
EMPLOYEE NAME					WORK ADDRESS (STREET AND NUMBER)				
WORK PHONE #					OCCUPATION				
RELATIONSHIP TO PATIENT					STATE				
CITY					ZIP				

PRIMARY INSURANCE INFORMATION									
<input type="checkbox"/> 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					STATE				
CITY					ZIP				

SECONDARY INSURANCE INFORMATION									
<input type="checkbox"/> 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					STATE				
CITY					ZIP				

MATERNITY PRE-REGISTRATION									
ONCE YOUR BABY IS BORN, HE/SHE WILL BE PLACED ON YOUR: <input type="checkbox"/> PRIMARY INSURANCE <input type="checkbox"/> SECONDARY INSURANCE <input type="checkbox"/> WILL BE SELF PAY <input type="checkbox"/> 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					STATE				
CITY					ZIP				