LEXINGTON MEDICAL CENTER

RETURN TO: ADMITTING DEPARTMENT
2720 Sunset Blvd., West Columbia, SC 29169 • **Phone:** (803) 791-2560 • **FAX:** (803) 939-4531
YOU CAN ALSO GO TO LEXMED.COM AND PREREGISTER ONLINE.

Labor and Delivery Preadmission Form

PATIENT INFORMATION

Patient's Last Name (*): _____ First (*): _____ Middle Initial (*):_____

Social Security Number:_____ Patient's Maiden Name/Other Name: _____

Address (*):_____ City (*): _____ State (*):_____

ZIP Code (*): _____ County of Residence: _____ Patient's Date of Birth (*):_____

Home Telephone (*):_____ Date of Last Menstral Period:_____ Patient Doctor's Name:_____

Marital Status (*): ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasion ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Asian ☐ Unknown

Ethnicity (*): ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Patient Refused ☐ Unknown

Religion:_____ Church:_____ Minister:_____

Do you have any: ☐ Advanced Directives ☐ Healthcare Power of Attorney ☐ Living Will

Patient's Employer (*):_____ Employer Telephone (*):_____

Employer Address (*):_____ City: _____ State: _____ ZIP Code: _____

Employment Status (*): ☐ Full Time ☐ Part Time ☐ Student: ☐ Full Time ☐ Part Time ☐ Retired ☐ Military ☐ Self-employed ☐ Unemployed ☐ Disabled

SPOUSE'S INFORMATION

Name:_____ Social Security Number:_____ Home Telephone: _____

Address:_____ City: _____ State: _____ ZIP Code: _____

Employer:_____ Job Title:_____ Employer Telephone: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Student: ☐ Full Time ☐ Part Time ☐ Retired ☐ Military ☐ Self-employed ☐ Unemployed ☐ Disabled

NEXT OF KIN INFORMATION

Name:_____ Relationship:_____ Home Telephone: _____

Address:_____ City: _____ State: _____ ZIP Code: _____

(*) Required Field

RESPONSIBLE PARTY INFORMATION: If patient is a minor under 18

Name (*): _____ Social Security Number:_____

Relationship (*): _____ Home Telephone (*):_____

Address (*):_____ City (*): _____ State (*): _____ ZIP Code (*): _____

Employer (*):_____ Job Title (*):_____ Employer Telephone (*): _____

Employer Address (*):_____ City (*): _____ State (*): _____ ZIP Code (*): _____

PRIMARY INSURANCE

Insurance Company Name (*): _____

Subscriber Name (*):_____ Subscriber DOB (*):_____ Patient Relationship to Subscriber (*):_____

Group Number:_____ Employer: _____ Policy Number: (*) _____

Address:_____ City: _____ State: _____ ZIP Code: _____

Phone Number (*):_____ Subscriber: ☐ Male ☐ Female Employee ID Number:_____

SECONDARY INSURANCE

Insurance Company Name: _____

Subscriber Name:_____ Subscriber DOB:_____ Patient Relationship to Subscriber:_____

Group Number:_____ Employer: _____ Policy Number: _____

Address:_____ City: _____ State: _____ ZIP Code: _____

Phone Number:_____ Subscriber: ☐ Male ☐ Female Employee ID Number:_____

FINANCIAL RESPONSIBILITY

Each patient is responsible. If you are a self pay patient, please coordinate payment arrangements with the Lexington Medical Center Financial Counseling department at (803) 791-2490. If you are an insured patient, please be prepared to pay any associated fee.

•••SPECIAL NOTE TO NEW MOTHERS•••

Most insurance policies require that the insured member contact member services within 30 days of birth to add a newborn to the policy.

(*) Required Field