TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Email Security Disclaimer:

Health records may contain sensitive health information. You should treat health record information like your banking information and share it wisely with only trusted sources and take care to protect its confidentiality. It is important to know and understand that sending your health records and other communications through email is not secure. Although the likelihood may be low, you need to understand that there is a chance that the health information you include or attach to the email could be intercepted, read, accessed or re-disclosed by someone other than the intended recipient of your email. This is because the email and any attachments that you choose to send through this portal are not encrypted and based upon the fact that emails, even with encryption, can be “hacked” or intercepted or breached by others. If you are concerned about the security and privacy of your health information, you should utilize an alternative means of transmitting your health information.

By clicking here, I acknowledge and understand this disclaimer ☐

- Alternatively, if you do not wish to submit via email, you can mail or submit in person to:

  Torrance Memorial Medical Center
  Attn: Admitting/Patient Access Department
  3330 Lomita Blvd
  Torrance, CA 90505

- Please fully complete the Pre-Registration Form for your delivery and submit to PreRegistrationForm@tmmc.com.

- Once submitted, please allow 48 hours to receive a call from a Torrance Memorial Staff for any additional follow-up if required.

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PRE-REGISTRATION FORM

Return to:
Email: PreRegistrationForm@tmmc.com
Mail/In-Person: 3330 Lomita Blvd.
Torrance, CA 90505
(310) 517-4754

PATIENT INFORMATION

PATIENT LAST NAME	FIRST	MIDDLE INITIAL	SEX ☐ M ☐ F
SOCIAL SECURITY NO.		DATE OF BIRTH	
ARRIVAL TIME	ARRIVAL TIME	DEPARTMENT VISITING	
ADMITTING PHYSICIAN	DIAGNOSIS		
SURGERY DATE			
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
LOCAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
PERMANENT PHONE NO. ( )	LOCAL PHONE NO. ( )		
EMPLOYER NAME	EMPLOYER ADDRESS		
EMPLOYER TELEPHONE NO. ( )	OCCUPATION		
PERSON TO NOTIFY IN CASE OF EMERGENCY		RELATIONSHIP	
ADDRESS		PHONE NO. ( )	
DATE OF INJURY (IF ACCIDENT)	TIME	PLACE	WORK RELATED ☐ Y ☐ N
PARENTS DATE OF BIRTH IF PATIENT UNDER 18:	MOTHER:	FATHER:	

RESPONSIBLE PARTY INFORMATION (PRIMARY INSURANCE SUBSCRIBER)

SUBSCRIBER RELATIONSHIP TO PATIENT	☐ SELF ☐ OTHER (describe)		
SUBSCRIBER LAST NAME	FIRST	MIDDLE INITIAL	
SUBSCRIBER ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER PHONE NO. ( )	SOCIAL SECURITY NO.	DATE OF BIRTH	
EMPLOYER NAME	OCCUPATION		
EMPLOYER ADDRESS	EMPLOYER TELEPHONE NO. ( )		
PRIMARY INSURANCE CO.	POLICY NUMBER	GROUP NUMBER	
PHONE NO. ( )	AUTHORIZATION NO. (IF NEEDED)		
SECONDARY INSURANCE CO.	POLICY NUMBER	GROUP NUMBER	
SUBSCRIBER LAST NAME	FIRST	MIDDLE INITIAL	
SUBSCRIBER ADDRESS			
SUBSCRIBER RELATIONSHIP TO PATIENT	☐ SELF ☐ OTHER (describe)	DATE OF BIRTH	
SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER TELEPHONE NO. ( )	SUBSCRIBER OCCUPATION		

MISCELLANEOUS INFORMATION

RACE	ETHNIC ORIGIN	LANGUAGE SPOKEN	RELIGION
IF PREGNANT DUE DATE	DATE OF LAST MENSTRUAL PERIOD	PEDIATRICIAN	MARITAL STATUS
PRIMARY CARE PHYSICIAN OTHER PHYSICIAN (IF APPLICABLE)			

CHECK LIST

- ☐ BRING INSURANCE FORMS (FILLED OUT AND SIGNED)
- ☐ BRING INSURANCE CARDS
- ☐ BRING DEPOSIT OR DEDUCTIBLE
- ☐ LEAVE VALUABLES AT HOME (BRING POCKET CHANGE ONLY)