

Birthing Center Pre-Admission Reservation

COMPLETE THIS FORM, FRONT AND BACK. PLEASE PRINT.

Have you been a patient at Community Memorial Hospital before? YES NO

If yes, when? _____ Under what name? _____

PATIENT INFORMATION

Last name _____ First name _____ MI _____

Birth date _____ Age _____ Marital status _____ Maiden name _____

Mailing address _____

Home phone (____) _____ Social Security Number _____

Religion _____ Church/Religious Organization _____

As a matter of routine policy, the hospital's Pastoral Care Services department notifies parishes daily (Monday-Friday). Would you like us to notify your parish/religious organization when you come to the hospital? YES NO

Your doctor _____ Baby's doctor (at CMH) _____

Date of your last menstrual period _____ Your baby's due date _____

Do you have an Advance Directive such as a Living Will or Power of Attorney for Health Care? YES NO
Would you like to receive information about completing an Advance Directive? YES NO
Would you like the opportunity to complete an Advance Directive? YES NO

Do you have any allergies? _____
(Example: medications, latex, food, soaps, dyes, environment, etc.)

PATIENT'S EMPLOYER INFORMATION

Name _____ Phone (____) _____

Address _____

EMERGENCY CONTACT PERSON

(Someone other than the person who will bring you to the hospital)

Name _____ Relationship _____

Daytime phone (____) _____ Evening phone (____) _____

SPOUSE'S INFORMATION (FATHER OF BABY OR SIGNIFICANT OTHER)

Last name _____ First name _____ MI _____

Birth date _____ Social Security Number _____

CONTINUED on back >>>

PRIMARY INSURANCE

Name of insurance _____ Subscriber _____

Policy/ID number _____ Group number _____

Claims mailing address _____

Customer Service phone number _____

Employer issuing policy _____

Employer's address _____

Will your baby be covered under this insurance policy? YES NO

SECONDARY INSURANCE

Name of insurance _____ Subscriber _____

Policy/ID number _____ Group number _____

Claims mailing address _____

Customer Service phone number _____

Employer issuing policy _____

Employer's address _____

Will your baby be covered under this insurance policy? YES NO

BABY'S INSURANCE

(Complete only if different from primary or secondary insurance)

Name of insurance _____ Subscriber _____

Policy/ID number _____ Group number _____

Claims mailing address _____

Customer Service phone number _____

Employer issuing policy _____

Employer's address _____

Please contact your insurance plan for prior authorization before your due date to ensure proper payment. According to insurance law, if the child is a dependent covered equally under two policies, the policy issued to the parent with the earliest birth date (month and day only) is primary for the child.

If possible, attach a copy (front and back) of your insurance card.

Signature _____ Date _____