

# ***Birth 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 \_\_\_\_\_

Race \_\_\_\_\_ Language Spoken \_\_\_\_\_ Translator Needed  YES  NO

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 INVOLVED OTHER)**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

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**PRIMARY INSURANCE**

Name of Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_ Customer Service Ph. # \_\_\_\_\_

Employer Issuing Policy \_\_\_\_\_

Employer's Address \_\_\_\_\_

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

**SECONDARY INSURANCE**

Name of Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_ Customer Service Ph. # \_\_\_\_\_

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 Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Policy /ID# \_\_\_\_\_ Group # \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_ Customer Service Ph. # \_\_\_\_\_

Employer Issuing Policy \_\_\_\_\_

Employer's Address \_\_\_\_\_

Please contact your insurance plan for prior authorization before your due date to ensure proper payment. According to most insurance companies, the child shall be covered under the mother's insurance policy as part of the delivery (if the insurance policy has maternity benefits). If the child will be equally covered under two policies, the mother's policy will be primary during the 2 or 4 days federally mandated post-delivery stay. If the child's stay exceeds 2 or 4 days, then the policy issued to the parent with the earliest birthdate (month and day only) is primary for the child.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_