CHI St. Joseph Health

Pre-Registration Form for Obstetrics Patients

Patient Name:_____
Last First Middle Maiden

Mailing Address: _____
Street/PO Box City State Zip Code

Home Phone Number (____) _____ Alternative Number (____) _____

Social Security Number _____ - _____ - _____ Date of Birth _____ /_____ /_____

Marital Status: Single Married Divorced Separated Race: _____

Religious Preference: _____ Church Attending: _____

Would you like us to contact your church and let them know you are a patient when you are admitted? Y N
Would you like to be included in our Pastoral Care Census? Y N

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip Code

Work Phone Number (____) _____ Extension _____ FT or PT

Spouse's Name/Next of Kin: _____ Relationship: _____

Spouse's/Next of Kin's Address: _____
Street/PO Box City State Zip Code

Spouse's/Next of Kin's Employer: _____ Alternative Number (____) _____

Nearest Relative Other Than Above: _____ Relationship: _____

Relative's Address: _____
Street/PO Box City State Zip Code

Relative's Phone Number (____) _____ Alternative Number (____) _____

Due Date: _____ OB Doctor's Name/Prenatal Clinic: _____

Date of last menstrual period: _____ Family/Primary Physician: _____

List any allergies to medications or foods: _____

Do you smoke? Y N Are you allergic /sensitive to latex? Y N Are you a Veteran? Y N

Do you have an Advance Directive or Medical Power of Attorney? Y N

If no, would you like help writing one while you are in the hospital? Y N

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Patient/Newborn Insurance Information

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder's Date of Birth: _____ /_____ /_____ Social Security Number _____ - _____ - _____

Is Insurance through an employer? Y N If yes, Name of Employer: _____

Mailing Address and Phone Number for Claims:

_____

(Please attach a legible copy of both front and back of insurance card)

Will the newborn be covered under the same insurance as the mother? Y N

If no, please provide the insurance information for the newborn:

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder's Date of Birth: _____ /_____ /_____ Social Security Number _____ -_____ - _____

Is Insurance through an employer? Y N If yes, Name of Employer: _____

Mailing Address and Phone Number for Claims:

_____

(Please attach a legible copy of both front and back of insurance card)

These forms may be returned to the admission desk in the lobby of the CHI St. Joseph Health College Station Hospital