

Label

O.B. PRE-ADMISSION REGISTRATION

To streamline your hospital admission, please submit the following before your delivery date.

OPTIONS FOR SUBMITTING YOUR INFORMATION:

- | | | |
|---|---|--|
| <p>1 Deliver form to any Hospital Registrar Staff at our Information Desk, Check-in Desk or ER Admitting Desk</p> | <p>2 FAX completed form, and a legible photocopy of the front and back of your health insurance card, to:
 952 • 853 • 8733
 Hospital Registration Staff</p> | <p>3 Mail or Deliver</p> <ul style="list-style-type: none"> ✓ completed form ✓ copy of your ID or driver's license ✓ copy of the front and back of your health insurance card, to:
 Admitting - Hudson Hospital
 405 Stageline Road Hudson, WI 54016 |
|---|---|--|

PLEASE PRINT

Have you been a patient at Hudson Hospital before? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the expected date of birth?
Who is your primary doctor?	Who will be the baby's doctor?
Who is your OB/Gyn?	Are you expecting twins? <input type="checkbox"/> No <input type="checkbox"/> Yes
Would you like to receive visitors during your stay? <input type="checkbox"/> Yes <input type="checkbox"/> No (Marking no means NO visitors or gift deliveries)	
Have you checked with your insurance provider to determine your obstetric coverage and whether you need to notify them upon your admission to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please check with your insurance provider before returning this form.)	

PATIENT INFORMATION				
	Last Name	First	Middle	
Social Security # _____ - _____ - _____	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced			
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth: ____/____/____	Maiden/Previous Name/AKA		
Street Address	City	State	Zip	
Home Phone _____ - _____ - _____	Work Phone _____ - _____ - _____ Ext. _____			
Occupation	Employer Name & Mail Address	City	State	Zip
<input type="checkbox"/> full-time <input type="checkbox"/> part-time <input type="checkbox"/> not employed <input type="checkbox"/> student full time <input type="checkbox"/> student part-time <input type="checkbox"/> self employed <input type="checkbox"/> not working/ looking <input type="checkbox"/> homemaker <input type="checkbox"/> disabled <input type="checkbox"/> hospital patient or resident of other institutions <input type="checkbox"/> other classification <input type="checkbox"/> sheltered/non-competitive employment				Religious Preference

GUARANTOR INFORMATION (Person responsible for payment)				
	Last Name	First	Middle	
Relationship to patient: <input type="checkbox"/> Self (if 18 years old or older) (if Self is selected skip to next section) <input type="checkbox"/> Parent <input type="checkbox"/> Other, describe:				
Social Security # _____ - _____ - _____	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced			
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth: ____/____/____	Maiden/Previous Name/AKA		
Street Address	City	State	Zip	
Home Phone _____ - _____ - _____	Work Phone _____ - _____ - _____ Ext. _____			
Occupation	Employer Name & Mailing Address	City	State	Zip


PATIENT HEALTH INSURANCE INFORMATION		
Insurance Carrier:		
Insurance Carrier's I.D. #	Policy Holder's Name	Relationship to Policy Holder
Policy # / Group #	Policy Holder's Date of Birth	Policy Holder's Employer

BABY HEALTH INSURANCE INFORMATION		
Insurance Carrier:		
Insurance Carrier's I.D. #	Policy Holder's Name	Relationship to Policy Holder
Policy # / Group #	Policy Holder's Date of Birth	Policy Holder's Employer

EMERGENCY NOTIFICATION	
Name of person to be contacted	Relationship to Patient
Home Phone _____ - _____ - _____	Work Phone _____ - _____ - _____ Ext. _____
Name of person to be contacted	Relationship to Patient
Home Phone _____ - _____ - _____	Work Phone _____ - _____ - _____ Ext. _____

Baby Demographics	
When your baby is born, what ethnicity would you like documented in baby's chart? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline to Answer	
When your baby is born, what race would you like documented in baby's chart? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Choose not to answer <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	

Thank you for choosing the Hudson Hospital Birth Center for your care.


Hudson Hospital & Clinic
HealthPartners