MATERNITY PRE-REGISTRATION FORM

DUE DATE	FAMILY PHYSICIAN (FOR MOTHER)	OBSTETRICIAN	MIDWIFE

CHECK THE BOX OF THE HOSPITAL WHERE YOU ARE DELIVERING:

☐ St. Joseph Medical Center
☐ St. Francis Hospital

PATIENT INFORMATION

PATIENT LEGAL NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER

PATIENT LEGAL ADDRESS	CITY, STATE, ZIP	HOME TELEPHONE ( )

PATIENT EMPLOYER NAME	WORK TELEPHONE & EXTENSION ( )	OCCUPATION

PATIENT EMPLOYER ADDRESS	CITY, STATE, ZIP

EMPLOYMENT STATUS	MARITAL STATUS	HAVE YOU BEEN A PATIENT AT ST. JOSEPH MEDICAL CENTER, ST. FRANCIS HOSPITAL, ST. CLARE HOSPITAL OR ST. ANTHONY HOSPITAL BEFORE? IF SO, WHAT NAME WAS USED?
☐ FULL-TIME ☐ UNEMPLOYED ☐ PART-TIME ☐ RETIRED	☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ MARRIED ☐ DIVORCED	

EMERGENCY CONTACT (NAME TWO, NOT AT THE SAME ADDRESS)

NAME OF PERSON TO NOTIFY	RELATIONSHIP TO PATIENT	HOME TELEPHONE ( )	WORK TELEPHONE & EXTENSION ( )

ADDRESS	EMPLOYER NAME

NAME OF PERSON TO NOTIFY	RELATIONSHIP TO PATIENT	HOME TELEPHONE ( )	WORK TELEPHONE & EXTENSION ( )

ADDRESS	EMPLOYER NAME

PERSON WHO CARRIES PRIMARY INSURANCE AND/OR FINANCIAL RESPONSIBILITY FOR THIS HOSPITALIZATION

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	AGE	SEX	RELATIONSHIP TO PATIENT

ADDRESS	CITY, STATE, ZIP	HOME TELEPHONE ( )

EMPLOYER NAME	WORK TELEPHONE & EXTENSION ( )	OCCUPATION	SOCIAL SECURITY NUMBER

EMPLOYER ADDRESS	CITY, STATE, ZIP	EMPLOYMENT STATUS	MARITAL STATUS
		☐ FULL-TIME ☐ UNEMPLOYED ☐ PART-TIME ☐ RETIRED	☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ MARRIED ☐ DIVORCED

ADVANCE DIRECTIVE

DO YOU HAVE A LIVING WILL?	DURABLE POWER OF ATTORNEY FOR HEALTH CARE?	LOCATION OF LIVING WILL/DURABLE POWER OF ATTORNEY	RELIGION
☐ YES ☐ NO	☐ YES ☐ NO		

BRING CURRENT MEDICAID IDENTIFICATION CARD, MEDICARE AND/OR INSURANCE CARDS AT TIME OF ADMISSION.

PRIMARY INSURANCE

INSURANCE PLAN NAME	ADDRESS	TELEPHONE ( )
GROUP#	SUBSCRIBER/POLICY/MEMBER #	INDIVIDUAL POLICY ☐ YES ☐ NO
COMMERCIAL PLAN ☐	POLICY #	GROUP #
BASIC HEALTH PLAN ☐	POLICY #	GROUP #
HEALTHY OPTIONS ☐	POLICY #	CLIENT ID #
DSHS ☐	CLIENT ID #	OTHER

SECONDARY INSURANCE

INSURANCE PLAN NAME	ADDRESS	TELEPHONE ( )

SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER

GROUP #	SUBSCRIBER/POLICY/MEMBER #	INDIVIDUAL POLICY

SOME INSURANCE SUPPLEMENTS/SECONDARY INSURANCE COMPANIES REQUIRE PREAUTHORIZATION FOR MAXIMUM HOSPITAL BENEFITS.

TO BE PREREGISTERED PRIOR TO DELIVERY, PLEASE EITHER ATTEND OUR WELCOME TO OUR HOME RECEPTION, MAIL THIS COMPLETED FORM, OR YOU MAY CALL US AT (866) 779-4347. WE WILL BE GLAD TO REGISTER YOU FOR THE BIRTH OF YOUR BABY. FAX 253-426-6609 OR MAIL TO SJMC P.O. BOX 2197, MS 01-05, TACOMA, WA 98401

SIGNATURE: _____ DATE: _____ PEDIATRICIAN: (FOR BABY) _____