BETHESDA HEALTH

Maternity Pre-Registration

Have you had services at Bethesda before? ______________________________

If yes, under what name: ______________________________

Date of Birth: ____________________ Social Security Number: ____________________

Legal first Name: ________________ Middle: __________ Last: ________________

Address: ______________________________

City: ____________________ Zip code: ________ Home phone: ________________

Cell phone number: ________________ Driver's license number: ________________

Primary language spoken in the home: ______________________________

Do you want us to list a religious affiliation (if yes, please state religion): ________________

Marital Status: Single ______ Married ______ Divorced ______ Widowed ______

Race: Asian ___ Black or African American ___ American Indian/Alaskan Native ___ White ___
Other ___ Decline to specify ___

Ethnicity: Hispanic _____ Non-Hispanic _____ Prefer not to answer _____

Would you like to list an e-mail address for us to send your registration confirmation number?
____

Place of employment: ______________________________

Employer phone number: ____________________ Occupation: ________________

Employer address: ______________________________

City: ______________________________ Zip code: ________________

Name of Spouse/Significant other: ______________________________

Address (if different): ______________________________

City: ____________________ Zip code: __________ Home phone: ________________

Name of Emergency Contact: ______________________________

Address (if different): ______________________________

City: ____________________ Zip code: ________ Home phone: ________________

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June 2011
Form #: PS 1480

If you have insurance that you'd like us to bill for you, please provide the following:

Name of Insurance Company: ____

Policy number: ______________________ Group number: __________________

Address for claims: ____

City: ____________________ Zip code: __________ Phone: ________________

Name of the subscriber: ____

If other than the patient, subscriber's date of birth _______________________________

Social security number: __________________ relationship: ____________________

If this is insurance through your employer or if you are a dependant on a group plan, please provide the name of the employer: ____

If you do not have insurance, please contact us at 561-737-7733, extension 84427. We will assist you with making financial arrangements.

When is your baby due: ____

Who is your Obstetrician: ______________________________________

Florida law requires that we inquire about Advance Directives. Do you have a living will? ____________ Do you have a health care surrogate? ______________

If yes, the name of your surrogate?_________________________________

If you would like information regarding Florida Advance Directives, please call us at **561-737-7733, extension 84427**. We will send information to your home.

Are you an organ donor?____ Please state the date of your last menstrual period: ________

Do you require any special assistance that our staff should be aware of for your upcoming service?
____

Please acknowledge that you have been provided with information about Bethesda's participation in the NICA plan. (This information is included in your maternity packet). Yes _____ No _____

MAIL THIS COMPLETED FORM TO:

Bethesda Hospital East
Attn: Admitting Department
2815 S. Seacrest Blvd.
Boynton Beach, FL 33435
FAX: 561-736-7263

NICA ENCLOSED