Hudson Hospital & Clinic
HealthPartners®

Label

O.B. PRE-ADMISSION REGISTRATION

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

OPTIONS FOR SUBMITTING YOUR INFORMATION:

1 **Deliver** form to any Hospital Registrar Staff at our Information Desk, Check-in Desk or ER Admitting Desk

2 **FAX** completed form, *and a legible photocopy of the front and back of your health insurance card,* to:
952 • 883 • 9727
Hospital Registration Staff

3 **Mail or Deliver**
- ✓ 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? ☐ Yes ☐ 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? ☐ No ☐ Yes
Would you like to receive visitors during your stay?: ☐ Yes ☐ 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? ☐ Yes ☐ No *(Please check with your insurance provider before returning this form.)*	

PATIENT INFORMATION	**Last Name**	**First**	**Middle**
Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐Married ☐Single ☐Widowed ☐Legally Separated ☐Divorced		
Sex: ☐**Female** ☐**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**
☐full-time ☐part-time ☐not employed ☐student full time ☐student part-time ☐self employed ☐not working/ looking ☐homemaker ☐disabled ☐hospital patient or resident of other institutions ☐other classification ☐sheltered/non-competitive employment			**Religious Preference**

GUARANTOR INFORMATION (Person responsible for payment)	**Last Name**	**First**	**Middle**
Relationship to patient: ☐ **Self (if 18 years old or older) (if Self is selected skip to next section)** ☐ **Parent** ☐ **Other, describe:**			
Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐Married ☐Single ☐Widowed ☐Legally Separated ☐Divorced		
Sex: ☐**Female** ☐**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**

See Reverse Side

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? ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer	
When your baby is born, what race would you like documented in baby's chart? ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Choose not to answer ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White	

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

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