OB REGISTRATION FORM

St. Mary's Hospital Madison, Wisconsin

PATIENT INFORMATION *Please Type or Print*

Patient's Name (Last, First, MI)	Previous Name (i.e. Maiden Name)	Birthdate (MM/DD/YY)	Social Security Number

Patient's Address (Street or P.O. Box)	City	State	Zip	Phone Number ( )	County

Marital Status	Religion	Church	Race	Ethnicity
☐Divorced ☐Separated ☐Married ☐Single ☐Widowed			☐American Indian or Alaskan Native ☐Black ☐White ☐Asian or Pacific Islander ☐Multicultural	☐Hispanic ☐Not of Hispanic Origin

What is your spoken language?	What is your written language?	Do you require an interpreter?
____________________	____________________	____________________

EMERGENCY NOTIFICATION

Name (Last, First, MI)	Relationship to Patient	Home Phone Number	Work Phone Number
		( )	( )
Name (Last, First, MI)	Relationship to Patient	Home Phone Number ( )	Work Phone Number ( )

PERSON RESPONSIBLE FOR BILL *(Patient or parent if patient is a minor or dependent)*

Name (Last, First, MI)	Relationship to Patient	Home Phone Number	Person to contact about bill while in the hospital:
		( )	☐Patient ☐Responsible Party

Address (Street, City, State, Zip Code)	Is Patient, Spouse or Parent a Wisconsin Veteran?	Is Patient applying for Wisconsin Medical Assistance?
	☐Yes ☐No	☐Yes ☐No

EMPLOYMENT INFORMATION 1 *(Patient or parent if patient is a minor or dependent)*

Employee Name	Relationship to Patient	EMPLOYED
		☐Full Time ☐Retired ☐Part Time ☐Self Employed ☐Disabled ☐Not Employed ☐Active Military Duty

Employer Name	Address (Street, City, State, Zip Code)	Phone Number
		( )

Student Status: ☐Full Time Student ☐Part Time Student

EMPLOYMENT INFORMATION 2 *(Patient or parent if patient is a minor or dependent)*

Employee Name	Relationship to Patient	EMPLOYED
		☐Full Time ☐Retired ☐Part Time ☐Self Employed ☐Disabled ☐Not Employed ☐Active Military Duty

Employer Name	Address (Street, City, State, Zip Code)	Phone Number
		( )

MEDICAL INFORMATION

OB Physician	Personal Physician
Due Date ____________________	Date of Last Menstrual Period ____________________

Revised 2/22/11

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S).

Please inform all insurance companies, covering mom and/or newborn, of this pregnancy and your intention to deliver at St. Mary's Hospital. **Failure to do so may result in a reduction of insurance benefits.** In addition, contact your employer(s) to have your newborn(s) added to your health insurance policy.

<table>
<tr><td rowspan="4">INSURANCE 1

This policy covers:

☐Mother & Baby
☐Mother Only
☐Baby Only</td><td>Insurance Company Name</td><td>Address (Street, City, State, Zip Code)</td><td>Phone Number
( )</td></tr>
<tr><td>Subscriber Name:
____
☐Active ☐Retired ☐Disabled</td><td>Birthdate (MM/DD/YY)</td><td>Social Security Number</td></tr>
<tr><td>Policy, Certification or Subscriber I.D. Number</td><td>Group Number</td><td>Effective Date</td></tr>
<tr><td>☐ Personal Policy
☐Cobra Continuation
☐Group/Employer Name
__________</td><td colspan="2">Have you notified this insurance company that you are having a baby?
☐ Yes
☐No If No, you must contact this insurance company before coming to St. Mary's Hospital.</td></tr>
<tr><td rowspan="4">INSURANCE 2

This policy covers:

☐Mother & Baby
☐Mother Only
☐Baby Only</td><td>Insurance Company Name</td><td>Address (Street, City, State, Zip Code)</td><td>Phone Number
( )</td></tr>
<tr><td>Subscriber Name:
____
☐Active ☐Retired ☐Disabled</td><td>Birthdate (MM/DD/YY)</td><td>Social Security Number</td></tr>
<tr><td>Policy, Certification or Subscriber I.D. Number</td><td>Group Number</td><td>Effective Date</td></tr>
<tr><td>☐ Personal Policy
☐Cobra Continuation
☐Group/Employer Name
__________</td><td colspan="2">Have you notified this insurance company that you are having a baby?
☐ Yes
☐No If No, you must contact this insurance company before coming to St. Mary's Hospital.</td></tr>
<tr><td>MEDICAL ASSISTANCE</td><td>Recipient's Name</td><td colspan="2">ID Number</td></tr>
<tr><td rowspan="3">☐ TRICARE
☐ CHAMPVA

This policy covers:

☐Mother & Baby
☐Mother Only
☐Baby Only</td><td>Sponsor Name (Last, First, MI)</td><td>Sponsor Birthdate (MM/DD/YY)</td><td>Social Security Number</td></tr>
<tr><td>Identification Card Number</td><td>Issue Date</td><td>Expiration Date</td></tr>
<tr><td>Branch of Service
☐ Air Force ☐Coast Guard ☐Navy
☐ Army ☐Marine Corp</td><td colspan="2">Military Status
☐ Active Duty ☐ Retired ☐ Deceased</td></tr>
<tr><td rowspan="2">MEDICARE</td><td>Name of Beneficiary</td><td colspan="2">Medicare Claim Number</td></tr>
<tr><td colspan="3">Has the patient had an overnight stay at any hospital within the last 60 days?
Name of Facility __________ From __________ (MM/DD/YY) To __________ (MM/DD/YY)</td></tr>
</table>

Relationship to Patient fields: Insurance 1, Insurance 2, and TRICARE/CHAMPVA sections each include "Relationship to Patient".