

Maternity Pre-Registration Form

Patient Information

Patient's Last Name (as listed on insurance card)		First Legal Name		MI	Date of Birth	Age	Social Security Number	
Street Address				City		State	Zip	Home Phone Number
Marital Status	Do you smoke?	Religious Preference		Name of Church		Official Estimated Delivery Date (NOT date of scheduled procedure)		
Physician/Obstetrician/Gynecologist/(If Nurse Midwife, give sponsoring Dr. Name)				Infant Physician (if known at time registration sent) Must be RMC physician*			Primary Care Physician	
Patient Employer						Occupation		
Employer Street Address				City		State	Zip	Employer Phone Number
Race (please check the one that most accurately describes your race): <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> HISPANIC/SPANISH/LATIN <input type="checkbox"/> HISPANIC-AFRICAN AMER ANCESTRY <input type="checkbox"/> NATIVE AMERICAN/ALASKAN/ALEUT <input type="checkbox"/> MULTI-RACIAL <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WHITE/CAUCASIAN <input type="checkbox"/> WEST INDIAN								

Spouse/Next of Kin Information

Last Name		First Legal Name		MI	Date of Birth	Age	Social Security Number	
Street Address (If different than above)				City		State	Zip	Home Phone Number
Spouse/Next of Kin Employer						Occupation		
Employer Street Address				City		State	Zip	Employer Phone Number

Emergency Contact (other than Spouse/Next of Kin)		Home Phone	Work Phone
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Insurance Information

Person assuming financial responsibility for account: (circle one) <div style="display: flex; justify-content: space-around; width: 100%;"> Self Spouse Other (please specify - parent, guardian, etc.): </div>							
Primary Insurance company name		Insurance Address			City	State	Zip
Insurance Phone Number	Policy/Certificate/ID Number		Group Number		Relationship		
Secondary Insurance company		Insurance Address			City	State	Zip
Insurance Phone Number	Policy/Certificate/ID Number		Group Number		Relationship		

*See "Before Baby Arrives - Choose your infant's physician"

REMEMBER:

Please send a photocopy of all your insurance cards and a copy of your photo ID (driver's license, passport).
 Please call the Hospital Admitting Office at 816-276-4532 if any of this information changes.
 Please remember to add your baby to the appropriate insurance policy after the baby is born.