OB PRE-ADMISSION REGISTRATION

GENERAL INFORMATION

Expected Delivery Date: .... Date of Last Menstrual Period: ....

Expected Type of Delivery (check one): ☐ Vaginal Delivery ☐ C-Section Delivery

PATIENT INFORMATION

Patient Name: .... Maiden Name: ....

Date of Birth: .... Social Security Number: .... Phone: (..........) ....

Race/Ethnic Background: .... Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: .... Apt #: ....

City: .... State: .... Zip: ....

Email: ....

PATIENT EMPLOYMENT INFORMATION

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Student

Employer/School Name: .... Occupation: ....

Employer Address: .... Work Phone: (..........) ....

City: .... State: .... Zip: ....

PHYSICIAN INFORMATION

Admitting Physician: .... Primary Care Physician: ....

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILLING)

Name: .... Relationship to Patient: ....

Date of Birth: .... Social Security Number: .... Phone: (..........) ....

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: .... Apt #: ....

City: .... State: .... Zip: ....

GUARANTOR EMPLOYMENT INFORMATION

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Student

Employer/School Name: .... Occupation: ....

Employer Address: .... Work Phone: (..........) ....

City: .... State: .... Zip: ....

RELATIVE/NEXT OF KIN

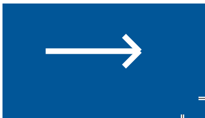
Name: .... Relationship to Patient: ....

Date of Birth: .... Work Phone: (..........) .... Cell Phone: (..........) ....

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: .... Apt #: ....

City: .... State: .... Zip: ....



MISCELLANEOUS INFORMATION

Denomination: .... Parish/Church/Synagogue/Temple: ....

PRIMARY INSURANCE INFORMATION

Name of Insurance Carrier: .... Plan Name: ....

Name of Insured: .... Patient Relationship to Insured: ....

Insured Social Security Number: .... Insured Sex: ☐ Male ☐ Female

Insured DOB: .... Policy #: ....

Group #: .... Group Name: ....

Claims Mailing Address: ....

City: .... State: .... Zip: ....

Pre-Certification/Authorization Phone #: (..........).................... Benefits Phone #: (..........)....................

SECONDARY INSURANCE INFORMATION

Name of Insurance Carrier: .... Plan Name: ....

Name of Insured: .... Patient Relationship to Insured: ....

Insured Social Security Number: .... Insured Sex: ☐ Male ☐ Female

Insured DOB: .... Policy #: ....

Group #: .... Group Name: ....

Claims Mailing Address: ....

City: .... State: .... Zip: ....

Pre-Certification/Authorization Phone #: (..........).................... Benefits Phone #: (..........)....................

NEWBORN PHYSICIAN INFORMATION

YOU WILL NOT BE DISCHARGED FROM THE HOSPITAL UNLESS YOUR CHILD'S PEDIATRICIAN RELEASES THEM

Select a Pediatrician

We recommend that you select a pediatrician or family practice physician before you come to the hospital for the birth of your baby. Please check with your insurance company for a list of providers as you make your selection. If you have not selected a physician prior to delivery, or if your physician does not have privileges at Baptist Health System, the hospital's on-call pediatrician will provide care for your baby while you are in the hospital.

Please complete this form and bring your photo ID and insurance card to the registration desk at your delivering facility:

Mission Trail Baptist Hospital
(210) 297-3000
3333 Research Plaza
San Antonio, TX 78235

Resolute Health Hospital
(830) 500-6900
555 Creekside Crossing
New Braunfels, TX 78130

St. Luke's Baptist Hospital
(210) 297-5000
7930 Floyd Curl Dr.
San Antonio, TX 78229

North Central Baptist Hospital
(210) 297-4000
520 Madison Oak Dr.
San Antonio, TX 78258

You can also register online at **www.BaptistHealthSystem.com/Patients/Pre-Register-Visit**