UW Medicine | VALLEY MEDICAL CENTER

REGISTRATION FOR OB/GYN AND HOSPITAL CARE

Patient Information

Please print and press firmly with a ballpoint pen

Please provide the following:

Name: _____ (Last) _____ (First) _____ (MI) _____ Prefer to be called

Address: _____ Age: _____ Birth Date: ___/___/___

Apartment or PO Box Number: _____ Marital Status: S M D W Sep (circle one)

City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

Employer: _____ (Name) _____ (City) _____ (Occupation) Work Phone: (_____) _____

Who referred you to our office? _____ Soc Sec: _____

OB/GYN Physician: _____ Family or Primary Care Physician: _____

Have you had services at Valley Medical Center before? (including x-ray or ER) Yes No (circle one)

Were you seen under a different name? If yes, former name: _____

Family Information

Husband/Partner or Parent Name: _____ Relationship to Patient: _____ Birth Date: ___/___/___

Soc Sec: _____ Employer: _____ (Name) _____ (City) Wk Phone: (_____) _____

Hm Phone: (_____) _____ If patient is a minor, who is their guardian? _____

Financial and Insurance Information

Please present Insurance Card(s) to Receptionist

Primary Insurance: _____ Secondary Insurance: _____

Group #: _____ Group #: _____

Subscriber #: _____ Subscriber #: _____

Policyholder Name: _____ Policyholder Name: _____

Ins. Co. Phone #: (_____) _____ Ins. Co. Phone #: (_____) _____

Newborn Information (if applicable)

Baby's Last Name: _____ Name of Baby's Doctor: _____

Due Date: _____ Baby's Insurance: ❑ Primary ❑ Secondary ❑ Other: _____

Who do you want us to communicate with about your care?

Primary Contact: _____ (or legal guardian, if same as family information, note SAME) Hm Phone: (_____) _____

Relationship to patient: _____ Alt Phone: (_____) _____

Alternate Contact: _____ Hm Phone: (_____) _____

Relationship to patient: _____ Alt Phone: (_____) _____

The hospital requests the following information to include as a part of your medical record:

Advance Directives: Do you have a living will? ❑ Yes ❑ No. Do you have a Healthcare Power of Attorney? ❑ Yes ❑ No

Religion: If you would like it included in your record, what is your religious preference? _____

Release of Benefits & Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims. I understand this may include information regarding HIV, sexually transmitted diseased, mental health, drug and or alcohol use.

SIGNED: _____ DATE: _____

96-1059 (1/12)

OFFICE USE ONLY:

Registration to Admitting at 12 weeks: Date sent: _____ Initials: _____