

Maternity Pre-Registration Questionnaire

Please print and complete all questions, and include a copy of your legal ID and all insurance cards (front and back). If you are not able to copy them, it is very important to bring them with you at the time of registration.

H	ospital Preference 🗆		Expected Due Date						
	Patient's Last Name First M			nitial	Marital Status		Allergies		
Patients Information	Race American Indian and Alaska Native Asian Black or African American Native Hawaiian and Other Pacific Islander Other Patient Refused White or Caucasian		□ Hispanic		y Language n / Church		Date of Birth (mm/dd/yyyy) Social Security No.		
									Physician's Last Name
	Patient's Street Address).	City St		te	Zip	
	Home Phone	e	Email Address						
	Patient's Current Employer Nan	me Employer Ado	dress		City St		te	Zip	
	Employer Phone					Employment Status: Not Employed Full Time Part Time Student			
	Full Name of Emergency Contact Relationship)	Home Phone Work Phone				
	Have you ever been a patient at Under what name?	If yes, when was your last visit?	Pediatrician	n/ Group					
	Spouse Information	Last Name	Mid	dle Initial	Relationship	Date of Birth (mm/dd/yyyy)			
Street Address Apt. No.				Primary Languag	nary Language Social Security No				
City State		Zip	Home Phone		Work Phone	Cell Phon	one		
Employer Name Employer Add		lress		City	State		Zip		
Employer Phone				Employment Status: Not Employed Full Time			□ Full Time		
es	Primary Insurance Company Name				□ Part Time □ Student Name of Insured exactly as appears on card				
suran	Insurance Billing Address	City		State Zip		Phone No.			
Primary Insurance Information	Policy No. (for BCBS, include 3 Group No. letter prefix)		Plan Code		State	State Effective Date		Expiration Date	
Prim: In	Subscriber's Full Name		Subscriber's Soc.	Sec. No.	Subscriber's Date of Birth (mm/dd/yyyy)		□ Female		

	Secondary Insurance Company Name:	Name of	Name of Insured exactly as appears on card							
Secondary Insurance Information										
	Insurance Billing Address		City	State	Zip	Phone No.				
				1	•	()			
	Policy No. (for BCBS, include 3 letter prefix)	Group No.	Plan Code	State	Effective D	ate	Expiration Date			
	Subscriber's Full Name		Subscriber's Soc. Sec. No.	Subscriber' (mm/dd/yy	s Date of Birth yy)	□ Female				
	Subscriber's Employer name (if self-emp	Relation to Insured	Subscriber'	s Employment S	tatus: 🗆 No	ot Employed				
	name)		□ Full Time	e 🗆 Part Time	□ Student	□ Retired and Date:				
	Subscriber's Employer Address	City S	tate	Zip	Ph	one No.				
Advan	ce Directive					()			
	nave an Advance Directive, such as	a Living Will	or Durable Power of Att	orney for H	lealth Care?	□ Yes	□ No			
Please sp	pecify the type:									
*** If ve	s, please bring a copy at the time o	f vour admissio	n***							
Self-Pa		, ,								
* If you are insured but your procedure is not covered by your plan, a deposit and /or your deductible will be required prior to, or at the										
time of a being adı	dmission. Please contact the <i>Finan</i>	ıcial Clearance	<i>Center</i> 630-933-5574 t	o speak wit	h a <i>Financial</i>	Counselo	r for details prior to			
	do not have insurance, please conta	ct our Financia	l Counselors at 630-93.	3-5574 befo	ore your sched	duled arriv	al date to discuss			
•	hat may be available based on finan	ncial eligibility.								
	onal Information need special accommodations, such	as Translation	Viewal Aid ata 2	Yes	□ No					
	s, please specify so that prior arran									
□ Lang	uage Interpreter	□ S	ign Language Interprete	er 🗆 Vi	sual aid	□ Other: _				
	(Language)									
Does you	ır insurance company require	: Any special Pre-Certific		dmission?			NO			
		rie-Ceruii	Sation?			YES	NO			
Your ins	urance company will be conta	cted by a Fin	ancial Clearance Ce	nter Repr	esentative.	A Financ	cial			
	or will call you regarding you	-								
	dmission. If you are enrolled i ysician. This will enable you to									
Care ping	ysician. This will chable you u	receive the i	naximum benefits av	anabie ui	idei youi ii	isui ance	ріан.			
	vation for Release of Informat		45141.	: C 4 : .			1			
	authorize Cadence Health to relectories or government agency to									
	with the requirement of any prof									
	re Organization for utilization re									
All Inform	nation is confidential.									
		Signature			Date					
Please fa	x or mail completed form wit	h a copy of yo	our insurance cards (front and	back) at le	ast one w	eek prior			
	dmission.						-			
	Mailing addre	Number								
	Cadence Health ATTN: Financ			-933-1326	1					

ATTN: Financial Clearance Center 1405 North 5TH Avenue Saint Charles, IL. 60174