



Chilton Memorial Hospital Maternity Pre-Admission Registration

Please print or type.

Patient Information

Patient Last Name

First Name

MI

Maiden Name

Admitting Physician

Baby's expected due date

Home phone (including area code)

Street

City

State

Zip code

Date of Birth

Social Security Number

Marriage Status: Married

Single

Widowed

Divorced

Legally Separated

Religion

Church Affiliation

Nearest Relative

Name

Relation

Address

Phone Number (Day)

(Evening)

Whom to notify in emergency

Name

Relation

Address

Phone Number (Day)

(Evening)

Insurance Information

Self-pay: Yes No

If yes, complete this form. Read and sign the release at the end of this registration form (no.16).
A Financial counselor will contact you regarding payment. Also, complete the attached Newborn
Registration form.

Does Patient have insurance in her own name to cover this admission? Yes No

Patient's Employer

Employer Address

Employer Phone Number

Type of Insurance

ID Number

Verification Phone Number

Does Spouse have insurance to cover this admission? Yes No

If yes:

Spouse's Name

Date of Birth

Social Security Number

Employer

Occupation

Employer Address

Employer Phone Number

Type of Insurance

ID Number

Verification Phone Number

Any additional hospital coverage? Yes No

Please read and sign below.

I am aware that Chilton Memorial Hospital will use this information to attempt to pre-verify my insurance coverage.

To the best of my knowledge, the attached information is complete and accurate.

Signature

Date

Would you like a Financial Counselor to contact you to discuss any concerns you may have regarding your hospital bill (payment plans, deposits, financial assistance)? Yes No

Please complete the Newborn Registration form