Please print clearly and complete all information requested & provide copy of front and back of insurance card

Dignity Health.

OBGYN Doctor _____

Pediatrician _____

Expected date of delivery _____

Pre-Admission Information

Please check which hospital you will be delivering your baby.

☐ **Chandler Regional Medical Center**
1955 W. Frye Rd. | Chandler, AZ 85224-0051
Admitting Department
480.728.3698 | Fax: 480.728.3233

☐ **Mercy Gilbert Medical Center**
3555 S. Val Vista Dr. | Gilbert, AZ 85297-7323
Admitting Department
480.728.7174 | Fax: 480.728.9622

Please call our Admitting Department at the hospital you will be delivering your baby for any assistance you require to complete this Pre-Admission Registration Form or any other questions you may have about your hospital stay.

PATIENT INFORMATION

Patient's Legal Name (Last, First, M.I.) | Maiden or Previous Name

Address | Phone Number

City, State, Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other _____

Date of Birth | Social Security Number | Religious Preference

Employer (if unemployed, please state) | Occupation | Employer's Phone Number

Email Address: | Baby's Email Address ☐ Check if same

This email address is used to access your online Patient Portal. For more information about the portal, visit DignityHealth.org/Patients.

NOTIFY IN CASE OF EMERGENCY

Please list two people we can contact in case of emergency.

Name (Last, First, M.I.) | Relationship | Phone Number

Address (Street, City, State, Zip) | Date of Birth

Name (Last, First, M.I.) | Relationship | Phone Number

Address (Street, City, State, Zip) | Date of Birth

PRIMARY INSURANCE INFORMATION

Insurance Company | ID Number | Group / Policy Number

Policy Holder's Name | Relationship to Patient | Date of Birth | Social Security Number

Insurance Company Address (Street, City, State, Zip) | Phone Number

Employer Name & Address | Phone Number

SECONDARY INSURANCE INFORMATION

Insurance Company | ID Number | Group / Policy Number

Policy Holder's Name | Relationship to Patient | Date of Birth | Social Security Number

Insurance Company Address (Street, City, State, Zip) | Phone Number

Employer Name & Address | Phone Number