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

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 ______________________