

## MATERNITY PRE-REGISTRATION FORM

Sierra Nevada Memorial Hospital  
155 Glasson Way, Grass Valley, CA 95945  
Registration Department 530.274.6706

Please return the form to the Registration Department in building 3  
( 4-6 weeks prior to delivery)

Due Date:		Doctor:		Date of Birth	
Patient Name (First, Middle, Last):				Maiden/Other:	
Address:			Email Address:		
City:		State:	Zip Code:		Phone:
Marital Status:		Race:		Religious Preference:	
Employer:				Patient SSN:	
Phone:		Occupation:			
Next of Kin:			Relationship:		
Address:					
City:		State:	Zip Code:		Phone:
Person to Notify:			Relationship:		
Address:					
City:		State:	Zip Code:		Phone:
Insurance #1:					
Address:					
City:		State:	Zip Code:		Phone:
Subscriber Name:			Relationship:		
ID#:		Group#:		Effective Date:	
Insurance #2:					
Address:					
City:		State:	Zip Code:		Phone:
Subscriber Name:			Relationship:		
ID#:		Group#:		Effective Date:	
Insurance Coverage for Baby:					
Insurance:					
Address:					
City:		State:	Zip Code:		Phone:
Subscriber Name:			Relationship:		
ID#:		Group#:		Effective Date:	

## Notice of Privacy Practices for Health Information (NPP) Acknowledgement Form

Effective April 14, 2003, the law requires that Sierra Nevada Memorial Hospital give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Acknowledgement Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
(if signed by someone other than patient)

### For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Hospital Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Department: \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES FOR HEALTH INFORMATION (NPP) ACKNOWLEDGEMENT FORM**



\* N P P \*

SPSSNM00208 (5-15)

Patient Identification

Place Patient Label Here