

Maternity Admission Application

Account # _____ Date _____
 Registrars Initials _____
 Date Rec'd _____ Initials _____
 Letter Mailed _____ Initials _____
 Date Rec'd by verifier _____ initials _____
 Financial Responsibility \$ _____

FOR HOSPITAL USE ONLY

Please type or print clearly; fill in all spaces. Please submit along with a copy of your identification and your insurance card both front and back.

PATIENT	Patient's Legal Name Last: _____ First: _____ Maiden Name _____			
	Address _____ Apt.# _____		Phone (____) _____ Social Security # _____	
	City _____	State _____	Zip _____ Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of Birth _____	Place of Birth _____	Race <input type="checkbox"/> AI/ES/AL <input type="checkbox"/> AS/PI <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> W Hispanic <input type="checkbox"/> B Hispanic <input type="checkbox"/> Other Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
	Employment Status - Are You <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Military			
	Employer _____		Employer phone / ext. (____) _____	
	Employer Address _____		Occupation _____	
	City _____	State _____	Zip _____ Have you ever been treated at Baptist Health South Florida before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Religion _____	Church/Synagogue _____	Tubal ligation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	DUE DATE _____	PATIENTS PHYSICIAN (O.B DOCTOR) _____	Is a Cesarean Section expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Would you accept blood or blood products in the event of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Financial Contact (person to contact regarding insurance and financial matters) Name: _____ Relationship: _____ Phone: _____			
	Please provide an emergency contact of friend, neighbor or relative (Other than spouse.) Name: _____ Relation: _____ Phone: _____			
	Spouse or Person responsible for insurance. Not Patient.	Spouse's/Other's Legal Name Last: _____ First: _____ MI: _____		Date of Birth: _____
		Address (if different from above) _____		Phone: (____) _____
Employment Status: - are you <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Military		Social Security #: _____		
Employer _____		Occupation _____	Employer phone / ext. _____	
Employer Address _____ City _____ State _____ Zip _____				
INSURANCE	Complete the Insurance Section only if you are Covered For Maternity Benefits, "Well Baby" Charges and/Or Complications			
	Insurance Company (Carrier) _____	Policy is: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other <input type="checkbox"/> Group <input type="checkbox"/> Individual	Insurance Co. Phone #: _____	
	Insurance Company Address _____ City _____ State _____ Zip _____			
	Policy /Subscriber ID #: _____	Group #: _____	If Group Policy, give name of employer: _____	
	Insurance Company (Carrier) _____	Policy is <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other <input type="checkbox"/> Group <input type="checkbox"/> Individual	Insurance Co. Phone #: _____	
	Insurance Company Address _____ City _____ State _____ Zip _____			
	Policy / Subscriber ID #: _____	Group# _____	If Group Policy, give name of employer: _____	
	Does this policy cover the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Baby will be enrolled in : <input type="checkbox"/> Mother's Insurance <input type="checkbox"/> Father's Insurance		
Under a new federal privacy law, you may choose not to be listed in the telephone switchboard directory. This directory is only used in case a family member or friend tries to get in touch with you while you are in our facility. For your convenience, we recommend that you be listed in our directory. If you would like to opt out, we will give you a separate form to complete.				
OPT OUT: <input type="checkbox"/> YES <input type="checkbox"/> NO				