

# Maternity Pre-Registration Form

## Patient Information

Patient's Last Name (as listed on photo ID)		First Legal Name		MI	Date of Birth	Age	Social Security Number	
Street Address				City		State	Zip	Home Phone Number
Marital Status	Do you smoke?	Religious Preference		Name of Church		Official Estimated Delivery Date (NOT date of scheduled procedure)		
Physician/Obstetrician/Gynecologist/(If Nurse Midwife, give sponsoring Dr. Name)				Infant Physician (if known at time registration sent) Must be OPRMC physician*			Primary Care Physician	
Patient Employer						Occupation		
Employer Street Address				City		State	Zip	Employer Phone Number
Race (please check the one that most accurately describes your race): <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> HISPANIC/SPANISH/LATIN <input type="checkbox"/> HISPANIC-AFRICAN AMER ANCESTRY <input type="checkbox"/> NATIVE AMERICAN/ALASKAN/ALEUT <input type="checkbox"/> MULTI-RACIAL <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WHITE/CAUCASIAN <input type="checkbox"/> WEST INDIAN								

## Spouse, Next of Kin or Insurance Cardholder Information (if different than patient)

Last Name		First Legal Name		MI	Date of Birth	Age	Social Security Number	
Street Address (If different than above)				City		State	Zip	Home Phone Number
Spouse/Next of Kin Employer						Occupation		
Employer Street Address				City		State	Zip	Employer Phone Number

Emergency Contact (other than Spouse/Next of Kin)		Home Phone		Work Phone	
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## Insurance Information

Patient Relationship to Primary Insurance Cardholder (circle one) <div style="display: flex; justify-content: space-around;"> <span>Self</span> <span>Spouse</span> <span>Other (please specify - parent, guardian, etc.):</span> </div>							
Primary Insurance company name			Insurance Address		City	State	Zip
Insurance Phone Number	Policy/Certificate/ID Number		Group Number		Relationship		
Secondary Insurance company			Insurance Address		City	State	Zip
Insurance Phone Number	Policy/Certificate/ID Number		Group Number		Relationship		

\*See "Before Your Baby Arrives - Find a pediatrician or family physician"

## REMEMBER:

- Please send a photocopy of all your insurance cards and a copy of your photo ID (driver's license, passport).
- Please remember to add your baby to the appropriate insurance policy after the baby is born.
- **If you anticipate having any difficulty in paying your portion of your hospital expenses, please call the Hospital Business Office for assistance. For last name A-L call 913-541-5321; M-Z call 913-541-5887.**
- If your envelope is missing you may mail to: **Maternity PreAdmission, Overland Park Regional Medical Center, 10500 Quivira Road, Overland Park, KS 66215** or if you prefer it can be e-mailed to **oprm.babies@hcahealthcare.com**.