Date of Last Menstrual Cycle

# Obstetric Pre-Registration

Date Received

**Choose hospital preference for delivery:**

❑ **Cape Coral Hospital, 636 Del Prado Boulevard, Cape Coral, Florida 33990**

❑ **HealthPark Medical Center, 9981 S. HealthPark Drive, Fort Myers, Florida 33908**

**Please complete this pre-registration form and attach copies of insurance cards, both front, and back. Email form and card copies to OBpreregistration@leehealth.org or send via U.S. Mail to selected hospital, attention Registration Services.**

| | | | | | |
|---|---|---|---|---|---|
| **Full Legal Name** | **Last** | **First** | **Middle** | | **(Maiden)** |
| **Legal Home Address** | **Street** | **City** | **State** | **Zip Code** | **County** |
| **Telephone** / **Cell** | **Social Security #** | **Birthdate** | ❑ **Married** ❑ **Divorced** ❑ **Single** ❑ **Legally Separated** ❑ **Widowed** | | |
| **Email Address** | | | | | |
| **Expected Delivery Date** | **Physician's Name** | | **Telephone** | | |
| **Employment Status** ❑ **Employed Full Time** ❑ **Employed Part Time** ❑ **Self Employed** ❑ **Not Employed** ❑ **Active Military** | | | **Employer's Name** | | |
| **Employer's Address** **Street Address** | **City** | **State** | **Zip Code** | **County** | **Phone** |
| **Race:** ❑ **Caucasian** ❑ **Asian** ❑ **African** ❑ **Other**_____ | **Language Preference:**_____ | | **Religion:**_____ | | |

## Expectant Father's Information

| | | | | | |
|---|---|---|---|---|---|
| **Full Legal Name** | **Last** | **First** | **Middle** | | **(Maiden)** |
| **Legal Home Address** | **Street** | **City** | **State** | **Zip Code** | **County** |
| **Telephone** | **Social Security #** | **Birthdate** | ❑ **Married** ❑ **Divorced** ❑ **Single** ❑ **Legally Separated** ❑ **Widowed** | | |
| **Employment Status** ❑ **Employed Full Time** ❑ **Employed Part Time** ❑ **Self Employed** ❑ **Not Employed** ❑ **Active Military** | | | **Employer's Name** | | |
| **Employer's Address** **Street Address** | **City** | **State** | **Zip Code** | **County** | **Phone** |

## Emergency Contact – Someone Other Than The Expectant Father

| | | | | | | |
|---|---|---|---|---|---|---|
| **Full Name** | **Last** | **First** | **Middle** | **Relationship to Mother** | | |
| **Home** | **Street** | **City** | **State** | **Zip Code** | **Home Phone** | **Work Phone** |

## Insurance Information – Please List All Health Policies

| | | | | | |
|---|---|---|---|---|---|
| ❑ **HMO** ❑ **PPO** | ❑ **Group** ❑ **Individual** | **Insurance Company** | **Policy Number** | **Group Number** | |
| **Insurance One** | **Maternity Benefits** ❑ **Yes** ❑ **No** ❑ **Complications Only** | **Policy Holder's Name** | **Group Name** | | |
| | **Benefits will cover baby** ❑ **Yes** ❑ **No** | **Effective Date** | **Insurance Company Phone** | **Pre-Certification Phone** | |
| | **Insurance Address** **Street** | **City** | **State** | **Zip Code** | |
| | **Medicaid** ❑ **Yes** ❑ **No** **If no, would you like to apply for Medicaid?** ❑ **Yes** ❑ **No** | | | | |
| ❑ **HMO** ❑ **PPO** | ❑ **Group** ❑ **Individual** | **Insurance Company** | **Policy Number** | **Group Number** | |
| **Insurance Two** | **Maternity Benefits** ❑ **Yes** ❑ **No** ❑ **Complications Only** | **Policy Holder's Name** | **Group Name** | | |
| | **Benefits will cover baby** ❑ **Yes** ❑ **No** | **Effective Date** | **Insurance Company Phone** | **Pre-Certification Phone** | |
| | **Insurance Address** **Street** | **City** | **State** | **Zip Code** | |
| | **Medicaid** ❑ **Yes** ❑ **No** **If no, would you like to apply for Medicaid?** ❑ **Yes** ❑ **No** | | | | |

**Do you wish visitors and phone calls?** ❑ **Yes** ❑ **No**

**Pre-Payment Plan (For patients with no Maternity Coverage)**

❑ **24 Hour Stay** ❑ **48 Hour Stay** ❑ **Scheduled C-Section**