Chilton Medical Center
ATLANTIC HEALTH SYSTEM

MATERNITY REGISTRATION INFORMATION

Please have Photo ID and Insurance cards available

Obstetrician's Name: _____ **Due Date:** _____

Primary Care Doctor: _____ **Pediatrician:** _____

Patient Information

Patient Name: (Last, First, & MI)		Sex:
Birthdate:	Social Security #:	Marital status: S W D M
Mailing Address:		Apt #:
City:	County:	State/Zip Code:
Email Address:		Home Phone #:
Race:	Nationality:	Can we leave a phone message?
Church:		Do you want a confidential address/phone?
Denomination:		Allergies:
Do you have a living will? No Yes	If yes, please enclose a copy.	

Alternate / Confidential Address

Resident Type:	College	Boarding school	Relative's home	Friend's home	Shelter

Address:	
City, State, & Zip code:	Can we mail to address?
Phone #:	Can we leave a phone message?

Patient's Employer Information

Are you employed:	Not Employed	Full time	Pt time	Student	Self employed	Military

Employer/school name:	Patient Occupation:
Employer Address:	Work Phone #:
City:	State/Zip Code:

Significant Other / Spouse's Information

Name: (Last, First, & MI)	Relation to Patient:
Birthdate:	Social Security #:
Mailing Address:	Home Phone #:
City:	State/Zip Code:

Employment Status:	Not Employed	Full time	Pt time	Student	Self employed	Military

Employer:	Occupation:
Mailing Address:	Work Phone #:
City:	State/Zip Code:

Notification in Case of Emergency (A second person to contact if desired)

Please notify: *(Name)*	Relation to Patient:
Address:	City, State, & Zip code:
Home Phone #:	Work Phone #:

Due to the multitude of variations with Insurance plans we cannot be responsible for knowing each individual patient's coverage plan. Therefore make sure that you familiarize yourself with your insurance plan, and keep us updated with any changes. If information is not received, incomplete, or inadequate we will have to register you as a "Self Pay Patient". This means you will be getting the bill from the hospital and will then have to submit the bill to your insurance company.

Primary Insurance Information			
Name of Insurance Company:		Insurance Plan:	
Policy #:	Group #:	Relation to Insured: Patient Relative Subscriber	
Address:		Phone #:	
City, State, & Zip code:			
Secondary Insurance Information			
Name of Insurance Company:		Insurance Plan:	
Policy #:	Group #:	Relation to Insured: Patient Relative Subscriber	
Address:		Phone #:	
City, State, & Zip code:			