Brookings HEALTH SYSTEM

300 22nd Ave
Brookings SD, 57006
Phone: 605 696-9000 Fax: 605 696-7758

Childbirth Preregistration Form

Dear Expectant Parents:
The information you provide on this form will assist with the admission preregistration. We realize the possible difficulties of answering questions upon admission; therefore, we have prepared this pre-registration form for your convenience. Please follow the instructions below when completing this form:

1. Complete and submit this form as early as possible after your first prenatal visit.
2. Use only full legal names including middle names.
3. Be as accurate as possible.
4. **Please mail this form to the Brookings Health System Business Office.**

Patient Information

Due Date_____ Birth date_____/_____/_____ Age_____
Patient Name_____ Maiden/Other Name _____
(last name, first name, middle name)
Mailing Address _____
County Patient Resides:_____
State_____ Zip Code_____ Home Phone #(___) _____
Marital Status Divorced Married Single Widowed Unknown
Soc Sec # _____
Employer_____ Mailing Address _____
City_____ State_____Zip Code _____
Employer Phone # ( )_____ Your Occupation _____
Admitting Physician:_____ Referring Physician:_____
Family/Primary Care Physician: _____
Do you have a living will? Yes No Do you have a durable power of attorney for health care? Yes No
If yes, please bring a copy when admitted.
Have you ever been a patient at the Brookings Health System? ___ Yes ___ No
Under what Name?_____
Are you eligible for Medicaid? ___ Yes ___ No
Are you eligible for Indian Health Services? ___ Yes ___ No
Are you eligible for Veteran's Administration? ___ Yes ___No
Would you like to discuss financial assistance? ___ Yes ___No

Spouse/Next of Kin

Father of Baby _____
(last name, first name, middle name)
Mailing address_____
City_____
State_____ Zip Code _____
Home Phone #(____)_____
Work Phone #(____)_____ Soc Sec # _____Birth date_____/_____/_____
Next of Kin_____
(last name, first name, middle name) Mailing Address _____
City_____ State_____ Zip Code _____
Home Phone # (__)_____Work Phone # (__) _____
Relationship to Patient_____

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Guarantor

If patient is 18 years or older they will be listed as guarantor.
If the guarantor is different please complete guarantor section.
Person Financially Responsible (Guarantor) _____
(last name, first name, middle name)
Mailing Address_____ City_____State_____ Zip Code _____
Home Phone # ( )_____ Soc Sec #_____
Relationship to Patient _____
Employer_____
Mailing Address _____
City_____ State_____
Zip Code _____
Phone # ( )_____ Occupation_____

Insurance

To ensure that we properly bill your insurance company, it is important to fill out the insurance information correctly. Please attach a copy of both sides of your insurance card. Some insurance companies require notification when an individual becomes pregnant and immediately after the baby is born. You may need preapproval for your hospital admission through your insurance company prior to admission. Please contact your insurance company to determine their requirements.

Primary Insurance_____ Mailing Address _____
City_____ State_____ Zip Code_____
Phone # ( ) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State _____
Secondary Insurance_____ Mailing Address _____
City_____ State_____ Zip Code_____ Phone # (___) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State _____

Baby Insurance Information (required only if baby added to different policy than primary)
Primary Insurance_____ Mailing Address _____
City_____ State_____ Zip Code_____ Phone # (___) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State ___
Secondary Insurance_____ Mailing Address _____
City_____ State_____ Zip Code_____ Phone # (___) _____
Policy #_____ Subscriber_____ Relationship to Patient _____
Group #_____ Employer_____ City_____ State _____

Thank you for choosing
Brookings Health System for your health care needs.