

# OBSTETRICS PRE-ADMISSION DATA

The information you provide assists with your admission. For questions, call Admissions at (605) 719-7858.

**Physician Name:** \_\_\_\_\_ **Expected Date of Delivery:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

*Last First Middle Maiden Name*

Address: \_\_\_\_\_  
*Street City State Zip*

Telephone #: \_\_\_\_\_ Religion: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status:  Single  Married  Separated  Divorced  Widowed

Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street City State Zip*

**Spouse / Significant Other Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street City State Zip*

**Relative (if other than above):** \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Would you like your medical information for you and the baby sent to your family physician? .....  Yes  No

If yes, Mother's Physician: \_\_\_\_\_ Baby's Physician: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Subscriber: \_\_\_\_\_ Policy #: \_\_\_\_\_ Grp#: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Subscriber: \_\_\_\_\_ Policy #: \_\_\_\_\_ Grp#: \_\_\_\_\_

**Bring your insurance card upon admission.**

Does this insurance company need PRE-AUTHORIZATION?  Yes  No

If yes, have you notified them?  Yes  No Pre-Authorization Phone #: \_\_\_\_\_ Ref. #: \_\_\_\_\_

**Attention T19 Card Holders:** You must present your T19 card to all providers at time of service.

T19#: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

After completing, fold, and tape this form so the return address is visible for mailing.  
Your prompt attention in completing this form is appreciated.