REGISTRATION
MATERNITY PREREGISTRATION

☐ Mercy Council Bluffs ☐ Bergan Mercy ☐ Creighton University Medical Center ☐ Immanuel ☐ Lakeside

PATIENT

Patient Last Name	First	Middle Initial	Previous Admission ☐ Yes ☐ No	Previous / Maiden Name

Expected Due Date	Sex ☐ M ☐ F	Age	Date of Birth	Ethnic Group ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Refused	Ethnic Background

Patient Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White or Caucasian ☐ Other ☐ Patient Refused ☐ Unknown	E-mail Address

Religion/Church	Obstetrician	PCP Doctor	Marital Status ☐ S ☐ M ☐ W ☐ D	Social Security Number

Street Address	City	State	ZIP + 4	Home Phone ( )

Employer Name	Address	Phone ( )

	Relationship	Address	Home Phone	Work Phone
Primary Contact			( )	( )
Secondary Contact			( )	( )

Fill Billing section out if under the age of 18

BILLING

Responsible Party Last Name	First	Middle Int	Address	City	State	Home Phone ( )

Relationship to Patient	Employer Name	Address	City	State	Phone ( )

Please complete section below or attach a copy of insurance card front and back. Bring insurance card and photo identification with you to hospital

INSURANCE INFO

Name of Insurance Company	Policy Number/Member Number	Group Number	Policyholder Name	Relationship

Claim Mailing Address	Policyholder Social Security Number	Policyholder Birth Date

Name of Other Insurance Co to Bill	Policy Number/Member Number	Group Number	Policyholder Name	Relationship

Claim Mailing Address	Policyholder Social Security Number	Policyholder Birth Date

*Many insurance companies require Preadmission Certification. If this requirement is not met prior to admission, your insurance benefits could be reduced or denied. Refer to your insurance card or contact your insurance company or your employer to determine the applicable procedure for you. A picture ID is required when checking in to the hospital.

Please return completed form no later than 60 days prior to due date.
Upon completion of this preregistration form, please return to the Registration Department by one of the following ways:

1. Secure Fax: (402) 398-6389
2. Mail To: CHI Health / Registration, 7500 Mercy Road, Omaha, NE 68124