IMPORTANT PAPERS FOR PRE-ADMISSION

Congratulations on choosing St. Elizabeth Healthcare for the birth of your baby. In order to make your registration process easier we need you to make an appointment after you have confirmed your pregnancy. **It may take 4-6 weeks before you can get an appointment. Please call 859-655-7400 to schedule your appointment.** During flu season no children under 14 yrs are permitted in the hospital. Flu restrictions normally run from Dec 1- April 1 (those dates may vary due to the severity of the flu). The visit will last approximately 30-40 minutes. You might want to leave small children at home for this appointment. **It is NOT necessary for your significant other to attend. You will be delivering at the Edgewood location, however we do offer Pre-Admission education at 4 locations for your convenience. Please let the scheduler know if you want the Edgewood, Florence, Ft. Thomas or Crittenden. If there are no forms attached to this page you may access and print them off @www.stelizabeth.com-go to Services. Family Birthplace, then to Pre-Admission Educator. Scroll down to the bottom to print forms. If possible, bring a copy of your insurance card, or we can copy it when you come to your appointment.**

We may call you prior to your appointment to complete the computer part of your visit over the phone to decrease your appointment time when you come in.

NO TOUR IS PROVIDED AT THIS VISIT.

The attached documents will need to be filled out and brought with you to the appointment:

1. **Registration Form for the admitting department.** Please fill out the front side and sign the back.
2. **Birth Certificate.** Please fill out the entire front side of this **EXCEPT** the Child information and Doctor information. If you are a single parent, **DO NOT** fill in any of the father's information. This will be filled in later after he has signed all the necessary paternity items.
3. **Authorization for Baby's Doctor.** Please try to have a Pediatrician selected before your pre-admission visit. If you do not have a doctor selected, we will provide you with a list. Many family doctors will also see your baby. You can get the most up to date pediatrician list at our website. www.stelizabeth.com to Quicklinks → Find a Doctor.

As part of your visit you will be required to watch an **EPIDURAL DVD**. This DVD will last **approximately 5 minutes**. It is a MANDATORY film from the anesthesiologists that any woman who wants to get an epidural must watch this video. If you attended or will be attending a childbirth class with this pregnancy, you will not be required to watch the video at your pre-admission education appointment.

Gravida_______ Para_______ EDD_______ LMP_______ **DATE OF LAB WORK**______________

Hepatitis__________ Beta Strep__________

Blood Type__________ Rh__________ RpR__________

Rubella Immune__________ Non-Immune __________

Your physician's office will complete the information listed to the side

BIRTH CERTIFICATE INFORMATION

MOTHER_______________ DOCTOR _______________ ROOM # __________

MOTHER'S CORP. #_______________

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)	2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Mo/Day/Yr)

5. FACILITY NAME (If not institution, give street and number)	6. CITY, TOWN, OR LOCATION OF BIRTH	7. COUNTY OF BIRTH
St. Elizabeth Healthcare	Edgewood	Kenton

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	8b. DATE OF BIRTH (Mo/Day/Yr)	AGE

8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)	8d. BIRTHPLACE (State, Territory, or Foreign Country)

9a. RESIDENCE OF MOTHER -STATE	9b. RESIDENCE OF MOTHER -COUNTY	9c. RESIDENCE OF MOTHER -CITY, TOWN OR LOCATION

9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS? ❒Yes ❒No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	10b. DATE OF BIRTH (Mo/Day/Yr)	AGE	10c. BIRTHPLACE

INFORMATION FOR ADMINISTRATIVE USE ONLY

14. MOTHER'S MAILING ADDRESS ❒ Same as residence, or State: City, Town, or Location:
Street and Number: Apartment No: Zip Code:

MOTHER

15. MOTHER MARRIED? (At birth, conception, or any time between) ❒ Yes ❒ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? ❒ Yes ❒ No

16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ❒Yes ❒No

17. FACILITY ID. (NPI) **65904**

18. MOTHER'S SOCIAL SECURITY NUMBER:

19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

Mother's Name__________ Due Date__________

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- ❒ 8th grade or less
- ❒ 9th - 12th grade, no diploma
- ❒ High School graduate or GED completed
- ❒ Some college credit but no degree
- ❒ Associate Degree (e.g.: AA, AS)
- ❒ Bachelor's Degree (e.g.: BA, AB, BS)
- ❒ Master's Degree (e.g.: MA, MS, MEng, MEd, MSW, MBA)
- ❒ Doctorate (e.g.: PhD, EdD) or Professional Degree (e.g.: MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "NO" box if mother is not Spanish/Hispanic/Latina.
- ❒ No, not Spanish/Hispanic/Latina
- ❒ Yes, Mexican, Mexican American, Chicana
- ❒ Yes, Puerto Rican
- ❒ Yes, Cuban
- ❒ Yes, other Spanish/Hispanic/Latina (Specify)__________

22. MOTHER'S RACE (Check one or more races to indicate what mother considers herself to be)
- ❒ White
- ❒ Black or African American
- ❒ American Indian or Alaska Native (Name of enrolled or principal tribe)__________
- ❒ Asian Indian
- ❒ Chinese
- ❒ Filipino
- ❒ Japanese
- ❒ Korean
- ❒ Vietnamese
- ❒ Other Asian (Specify)__________
- ❒ Native Hawaiian
- ❒ Guamanian or Chamorro
- ❒ Samoan
- ❒ Other Pacific Islander (Specify)__________
- ❒ Other (Specify) __________

23. MOTHER'S PRE-PREGNANCY WEIGHT __________(Pounds)

24. MOTHER'S HEIGHT __________(feet, inches)

26a. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either number of cigarettes or the number of packs of cigarettes smoked.
IF NONE, ENTER "O"
Average number of cigarettes or packs of cigarettes smoked per day

	# of cigarettes		# of packs
Three Months Before Pregnancy	______	OR	______
First Three Months of Pregnancy	______	OR	______
Second Three Months of Pregnancy	______	OR	______
Last Three Months of Pregnancy	______	OR	______

25. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ❒ Yes ❒ No

PHONE #__________

HEP. B. __________

26b. ALCOHOL USE
Alcohol use during pregnancy ❒ Yes ❒ No Avg. number drinks/week__________

FATHER

27. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- ❒ 8th grade or less
- ❒ 9th - 12th grade, no diploma
- ❒ High School graduate or GED completed
- ❒ Some college credit but no degree
- ❒ Associate Degree (e.g.: AA, AS)
- ❒ Bachelor's Degree (e.g.: BA, AB, BS)
- ❒ Master's Degree (e.g.: MA, MS, MEng, MEd, MSW, MBA)
- ❒ Doctorate (e.g.: PhD, EdD) or Professional Degree (e.g.: MD, DDS, DVM, LLB, JD)

28. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latina. Check the "NO" box if father is not Spanish/Hispanic/Latina.
- ❒ No, not Spanish/Hispanic/Latina
- ❒ Yes, Mexican, Mexican American, Chicana
- ❒ Yes, Puerto Rican
- ❒ Yes, Cuban
- ❒ Yes, other Spanish/Hispanic/Latina (Specify)__________

29. FATHER'S RACE (Check one or more races to indicate what father considers himself to be)
- ❒ White
- ❒ Black or African American
- ❒ American Indian or Alaska Native (Name of enrolled or principal tribe)__________
- ❒ Asian Indian
- ❒ Chinese
- ❒ Filipino
- ❒ Japanese
- ❒ Korean
- ❒ Vietnamese
- ❒ Other Asian (Specify)__________
- ❒ Native Hawaiian
- ❒ Guamanian or Chamorro
- ❒ Samoan
- ❒ Other Pacific Islander (Specify)__________
- ❒ Other (Specify) __________

Furnishing parent(s) Social Security Number(s) is required by Federal Law, 42 USC 405© of the Social Security Act. The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

__________ Mother's Signature __________ Date __________ Father's Signature __________ Date

#8210
REV. 4/04

PARENT(S) AUTHORIZE RELEASE OF CHILD'S SOCIAL SECURITY NUMBER TO THE OFFICE OF VITAL STATISTICS AND THE DEPARTMENT OF EDUCATION ❒ YES ❒ NO

ST. ELIZABETH HEALTHCARE

AUTHORIZATION FOR INFANT'S DOCTOR

I have chosen____

to be my baby's Doctor. I hereby give you permision to notify the above named doctor at the following address/phone number:

ADDRESS:____

____

____

____

PHONE:_______________________

____ ____________________

PARENT'S SIGNATURE DATE

____ ____________________

RN SIGNATURE - Initial Verification of Information DATE

____ ____________________

RN SIGNATURE - Reverification of Information upon arrival for delivery DATE

Edgewood, Florence, Ft.Thomas, Grant County, Covington

Name:____ Birthdate:_________ Soc. Sec. Number:_______________

Ob Doctor:________________________ Expected date of delivery:________ Maiden Name:______________________

Are you the primary insurance carrier? Yes or No

If so Employer Name and address:____

We will make a copy of your card at Pre-Admission

If No, please provide the Insurance Carrier's Information :

Subscriber:

Name:____ DOB:_________ Soc.Sec. Number:______________________

Address:____

Relationship to patient:______________________________

Employer:____

Occupation:____

Employer Address:____

We will add additional emergency contacts at your request when you pre-register. Please have address and telephone information available.

Admitting Department 301-5700

*** You only need to fill in the insurance information on the back if you will not have your card available to be copied when you register.**

ST. ELIZABETH HEALTHCARE
Edgewood, Florence, Ft.Thomas, Grant County, Covington

PRE-REGISTRATION

INSURANCE INFORMATION (CHECK FOR PRE-CERTIFICATION AUTHORIZATION)

Permission to verify benefits with your insurance companies____
Signature

(*You may replace insurance information requisted below with front and back copies of insurance cards.)

INSURANCE #1 (PRIMARY)

INSURANCE COMPANY NAME	SUBSCRIBER'S NAME / RELATIONSHIP TO SUBSCRIBER		
INSURANCE BILLING ADDRESS	CITY	STATE	ZIP
POLICY NUMBER	PLAN CODE	GROUP NUMBER	EFFECTIVE DATE

INSURANCE #2 (SECONDARY)

INSURANCE COMPANY NAME	SUBSCRIBER'S NAME / RELATIONSHIP TO SUBSCRIBER		
INSURANCE BILLING ADDRESS	CITY	STATE	ZIP
POLICY NUMBER	PLAN CODE	GROUP NUMBER	EFFECTIVE DATE

STATE MEDICAL ASSISTANCE (SMA), IF APPLICABLE

INSURED NAME	RECIPIENT NUMBER	RELATION TO INSURED		
SEX FEMALE	CASE NAME	CASE ID NUMBER	TPL NUMBER	DATES EFFECTIVE FROM________TO__________
PRIMARY CARE / KENPAC PROVIDER PHYSICIAN (LISTED ON CARD)				

CHAMPUS / CHAMPVA, IF APPLICABLE

DEPENDENT ❑ YES ❑ NO	SPONSOR SOCIAL SECURITY NUMBER	RANK / GRADE	
SERVICE	STATUS	ORGANIZATION	DATES EFFECTIVE FROM________TO__________
ID CARD NUMBER			