CONGRATULATIONS AND THANK YOU FOR CHOOSING ST. ELIZABETH FOR THE BIRTH OF YOUR BABY!

Now that you have a due date, please make an appointment to complete your pre-registration visit. This visit will make your registration and admission process go quickly and smoothly.

- **Pre-admission appointments are scheduled out four to six weeks. Please call (859) 655-7400 to schedule.** Even though all deliveries are at our Edgewood location, you may schedule your pre-admission appointment at Crittenden, Edgewood, Florence or Ft. Thomas. Please let the scheduler know which location you prefer.
- **This appointment will last 30-40 minutes, so you may want to leave small children at home.** Your significant other is welcome to attend, but it is not required.
- **Much of this visit consists of paperwork.** Please print the forms and complete as much as possible before your visit. Forms may be accessed online at stelizabeth.com.
  Select ➥ Medical Services Family Birth Place ➥ Pre-Admission ➥ Print Packet.

  The forms included are:

  ☐ **Registration form:** please complete both sides and sign.

  ☐ **Birth certificate form:** please fill out everything except the Child Information and Doctor Information sections.

  ☐ **Authorization for baby's doctor:** Please have a pediatrician selected before your appointment. If not, we will assist you in choosing one. A list of baby doctors is available at stelizabeth.com. In the site header, click "Find: Doctor." Under "Specialty," select "Pediatrics."
- **Bring a copy of your insurance card and your ID to the appointment.**
- **Someone may call you to complete the computer portion of your visit before your appointment.**
- **Unfortunately, there is no tour provided at this visit; however, you may schedule a tour separately.**
- **As part of the appointment, you will be asked to view an anesthesia video which lasts about five minutes.** This video is mandatory for anyone having a c-section or wishing to have an epidural.

Your physician's office will complete this section.

Gravida _____ Para _____ EDD _____ LMP _____ Date of lab work _____

Hep B _____ Beta Strep _____ Blood Type _____ Rh _____ RpR _____

Rubella Immune? yes / no

Revised: 6/2019

St. Elizabeth HEALTHCARE

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): **St. Elizabeth Healthcare**
6. CITY, TOWN, OR LOCATION OF BIRTH: **Edgewood**
7. COUNTY OF BIRTH: **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

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	_____

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

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

PHONE #_____

HEP. B. _____

Mother's Name_____ Due Date_____

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

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

#8210
REV. 4/04

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

St. Elizabeth HEALTHCARE

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