

OB PATIENT REGISTRATION FORM

HAVING A BABY IS ONE OF THE MOST EXCITING THINGS YOU WILL DO IN A LIFETIME. AT THE WOMEN'S HOSPITAL AT CENTENNIAL, WE SHARE IN YOUR EXCITEMENT AND ARE HONORED THAT YOU HAVE CHOSEN US FOR YOUR CARE.

Please complete and return this form a minimum of 4-6 weeks before your due date.

You may fax it to (615) 342-1585 or mail it to:
The Women's Hospital at Centennial
Attn: Admissions Department
2221 Murphy Avenue • Nashville, TN 37203

PATIENT INFORMATION

Legal Name: _____
Last First Middle
Social Security #: _____ - _____ - _____ Date of Birth ____/____/____ Marital Status: _____
Religious Preference: _____ Race/Ethnicity: _____ Primary Language: _____
Address: _____ City/State: _____ Zip: _____
Phone #: Home: (____) _____ - _____ Cell: (____) _____ - _____

Do you have a Living Will? (Circle One) Yes No
Do you have a Durable Power of Attorney for Healthcare? (Circle One) Yes No

Next of Kin: _____ Relationship to patient: _____ Phone #: (____) _____ - _____
Address: _____ City/State: _____ Zip: _____

Physician's Name: _____
Due Date: ____/____/____ Last Menstrual Cycle: ____/____/____

EMPLOYMENT INFORMATION

Check one: Self-Employed _____ Full Time _____ Part Time _____ Retired _____ Unemployed _____

If applicable:
Employer Name: _____ Phone #: (____) _____ - _____
Employer Address: _____ City/State: _____ Zip: _____

PRIMARY INSURANCE

***If you are uninsured or have an insurance question, please call the Financial Counselor's Office at (615) 342-1545. ***

Name of Policyholder: _____ Patient Relationship to Insured: _____ Policyholder date of birth: ____/____/____
Policyholder Social Security #: _____ - _____ - _____ Policy #: _____ Group #: _____
Insurance Company Name: _____
Insurance Company Address: _____ City/State: _____ Zip: _____
Phone#: (____) _____ - _____

SECONDARY INSURANCE INFORMATION

Name of Policyholder: _____ Patient Relationship to Insured: _____ Policyholder date of birth: ____/____/____
Policyholder Social Security #: _____ - _____ - _____ Policy #: _____ Group #: _____
Insurance Company Name: _____
Insurance Company Address: _____ City/State: _____ Zip: _____
Phone#: (____) _____ - _____

Upon arrival, we will complete the admission process in your room. Please have the following with you:

- Driver's License
- Advance Directives (Living Will/ Durable Power of Attorney for Healthcare)
- Insurance Card
- Co-Payment, Deductible, and Co-Insurance (due upon admission)

As a courtesy to you, we will contact your insurance company for verification of eligibility and insurance benefits. Our Financial Counselor's Office will contact you to review your insurance benefits and discuss financial options such as your estimated liability, payment plans, discounts, etc. If you have any financial questions, please contact us at (615) 342-1545. Thank you again for choosing The Women's Hospital at Centennial.