



FAMILY MATERNITY CENTER

Pre-registration Worksheet

MOTHER INFORMATION				Estimated Due Date:	
Last Name:		First Name:		MI:	
Physical Address:				Apt #:	
City:		State:	Zip:	Home Phone:	
Mailing Address				Apt #:	
City:		State:	Zip:		
Work Status: (circle one) Full Time Part Time Retired Unemployed Self Employed					
Employer:			Occupation:		
Address				Work Phone	
City:		State:	Zip:		
Date of Birth:		SSN:		Religion:	
Race/Ethnicity:			Do you have a Living Will or an AD? YES NO		
Marital Status: (circle one) Single Married Divorced Widowed Other:					
Mother's Family Doctor			OB/GYN		
Primary Language			Interpreter Required? YES NO		
Baby's Physician					

EMERGENCY CONTACT			
Last Name:		First Name:	Phone Number
Relationship to Mother:		Second Phone:	

MOTHER'S INSURANCE INFORMATION		<i>If possible, please attach a copy (front and back) of insurance card</i>			
Subscriber Last Name:		First Name:		MI:	
Address:		City/State/Zip:			
Home Phone:		Birthdate:		SSN:	
Employer:			Occupation:		
Address				Work Phone	
City:		State:	Zip:		
Insurance Co Name:			Customer Svc Phone:		
Insurance Address/City/State/Zip:					
Policy Number:			Group Number:		

BABY'S INSURANCE INFORMATION		<i>If possible, please attach a copy (front and back) of insurance card () Same as Mother</i>			
Subscriber Last Name:		First Name:		MI:	
Address:		City/State/Zip:			
Home Phone:		Birthdate:		SSN:	
Employer:			Occupation:		
Address				Work Phone	
City:		State:	Zip:		
Insurance Co Name:			Customer Svc Phone:		
Insurance Address/City/State/Zip:					
Policy Number:			Group Number:		

OTHER INFORMATION					
Are you entitled to Medicare based on (circle one) Disability Renal ESRD					
Are you employed? YES NO			If NO, what year did you retire?		
If married, is your spouse working? YES NO			If NO, what year did they retire?		

COMMENTS/NOTES	

Mail completed form to: Evergreen Hospital / Attn: Pre-registration MS-22 / 12040 NE 128th St, / Kirkland, WA 98034