

ALEGENT Health

REGISTRATION DEPARTMENT MATERNITY PREREGISTRATION

- Mercy Hospital Bergan Mercy Medical Center Midlands Community Hospital Immanuel Medical Center Lakeside Hospital
 800 Mercy Drive 7500 Mercy Road 11111 South 84th Street 6901 North 72nd Street 16901 Lakeside Hills Court
 Council Bluffs, IA 51503 Omaha, NE 68124 Papillion, NE 68046 Omaha, NE 68122 Omaha, NE 68130

Upon completion of this preregistration form, please mail to the Registration Department at the above address.

P A T I E N T	Patient Last Name		First	Middle Initial	Previous Admission <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous/Maiden Name	
	Expected Due Date		Sex	Age	Date of Birth	Religion	Church
	Obstetrician		PCP Doctor	Pediatrician	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep		Social Security Number
	Street Address			City	State	ZIP	Home Phone ()
	Employer Name			Address			Phone ()
	Primary Contact		Relationship	Address		Home Phone ()	Work Phone ()
	Secondary Contact		Relationship	Address		Home Phone ()	Work Phone ()

B I L L I N G	Responsible Party Last Name	First	Middle Initial	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 with you to hospital if card copy not attached.

I N S U R A N C E	Name of Insurance Company		Policy Number/Member Number	Group Number	Policyholder Name	Relationship
	Claim Mailing Address			Policyholder SS Number	Policyholder Birth Date	
	*Precertification Required <input type="checkbox"/> Yes <input type="checkbox"/> No		Authorization Number	Precertification Phone Number ()	Verification Phone Number ()	
	Name of Other Insurance Co to Bill		Policy Number/Member Number	Group Number	Policyholder Name	Relationship
	Claim Mailing Address			Policyholder SS Number	Policyholder Birth Date	
	*Precertification Required <input type="checkbox"/> Yes <input type="checkbox"/> No		Authorization Number	Precertification Phone Number ()	Verification Phone Number ()	

*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.

L A T E X Q U E S T I O N N A I R E	1. Do you have a latex allergy or sensitivity?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	2. Have you ever had an unexplained swelling, itching, wheezing, or hives:					
	a. Following a medical or dental procedure?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	b. After handling rubber products, balloons, or latex gloves?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
c. After eating tropical fruits such as kiwis, bananas or chestnuts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
3. What type of reaction did you experience?						
Explain: _____						

Nebraska Methodist Hospital Sheet

FATHER

If the mother is unwed at conception, birth, or any time between and the biological father's name is added to the birth certificate, both parents must sign an Acknowledgment of Paternity in the presence of a notary public. Identification is required. This must be completed and notarized at the Hospital.

FATHER OF NEWBORN:

Name: _____
First Middle Last (Suffix)

Marital Status: Single Married
 Widowed Divorced

Home Phone: _____ Work Phone: _____

Home Address: _____
Street City State Zip

Employer: _____

Employer's Address: _____
Street City State Zip

NEAREST RELATIVE (if different from above):

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

IMPORTANT INSURANCE INFORMATION:

It is your responsibility to contact your insurance for pre-certification prior to admission.

Primary Ins. _____ Secondary Ins. _____

Address: _____ Address: _____

Person Insured: _____ Person Insured: _____

Policy #/Group #: _____ Policy # /Group#: _____

Certificate/Subscriber #: _____ Certificate/Subscriber #: _____

Employer or Union: _____ Employer or Union: _____

Pre-certification #: _____ Pre-certification #: _____

Person Contacted: _____ Person Contacted: _____

Newborn's Insurance:

Primary Ins. _____ Secondary Ins. _____

Please bring insurance I.D. cards with you so a copy can be made to avoid delay in payment of claims.

Medicaid (Title XIX) Case #: _____ Medicare #: _____