

Maternity Pre-Admission Form

Copy of insurance card
attached Y N

PATIENT INFORMATION

Legal Name _____
Birth Date _____ Age _____
Address _____ City _____ County _____ Zip _____
Home Phone () _____ Marital Status _____
Social Security # _____ Religious Preference _____
Expected Due Date _____ OB Name _____
Primary Care Doctor _____

PATIENT EMPLOYMENT INFORMATION

Patient's Employer _____ Address _____
Work Phone Number () _____ Occupation _____

SPOUSE/PARENT INFORMATION

Name of Spouse/Parent (if insured by parents) _____ Social Security # _____
Address (if different from above) _____
Spouse/Parent Employer _____ Work Phone () _____
Spouse/Parent Employer Address _____
Name, address, phone and relationship of a local emergency contact _____

PRIMARY INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____
Address (if different) _____
Phone Number () _____
Relation to Patient _____
Primary Insurance Company Name _____ HMO / PPO / POS / OTHER
Address to mail claims to _____

Insurance Company Phone Number () _____
Primary Policy # _____ Group # _____ Certificate # _____
Pre-authorization Number _____ Effective Date _____

SECONDARY INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____
Address (if different) _____
Phone Number () _____
Relation to Patient _____
Primary Insurance Company Name _____ HMO / PPO / POS / OTHER
Address to mail claims to _____

Insurance Company Phone Number () _____
Secondary Policy # _____ Group # _____ Certificate # _____
Pre-authorization Number _____ Effective Date _____
Medicaid Coverage _____
Medicaid State I.D. # _____

If you have any financial questions or concerns, please call Financial Services at Swedish Medical Center, 303-788-6852.
If not insured, you may want to inquire about our self-pay discount plan and financial assistance programs.

RETURN TO: Swedish Medical Center
501 East Hampden Avenue
Englewood, Colorado 80113
Attn: ED Admissions Dept.

OR FAX TO: ED Admissions Dept. at 303-788-8906.