Pre-Registration

Stormont Vail Birthplace

Mother's Information

Name ____
(Last) (First) (Middle) (Maiden)

Address ____
(Street) (City) (State) (Zip Code)

Telephone ______________________________ E-mail______________________
(Home) (Work)

Age _____ Race ______________ Marital Status ____________ Date of Birth ____________ SS#________________

Religious Denomination _________________________ Expected Date of Delivery ________________________

Employer ______________________________________ Occupation ______________________

Employer's Address ____

Primary Insurance ____
(Company) (Address) (Telephone)

Policy Holder ____
(Name) (SS#)

Policy Number/ID Number _________________________________ Group Number _______________________

Secondary Insurance ____
(Company) (Address) (Telephone)

Policy Holder ____
(Name) (SS#)

Policy Number/ID Number _________________________________ Group Number _______________________

Have you ever been a patient at Stormont Vail Health? _________ If yes, when? _________________________

What was your name then? ____
(Last) (First) (Middle)

Will baby be added to mother's insurance? ❒ Yes ❒ No

Father's Information

Father of the Baby (or close relative) ____

Relationship ______________________________________ Date of Birth ______________________

Address ____
(Street) (City) (State) (Zip Code)

Telephone ______________________________ SS#______________________

Employer ______________________________________ Occupation ______________________

Employer's Address ____

Will baby be added to father's insurance? ❒ Yes ❒ No

Physician Information

Your Family Doctor ____

Your Obstetrician (if different from above) ____

Is there adoption involvement? ❒ Yes ❒ No

If yes, please list adoption agency____

Stormont Vail Birthplace
1500 S.W. 10th Ave.
Topeka, KS 66604
stormontvail.org

Please mail this form and a copy of your insurance identification card to Stormont Vail Health in the enclosed envelope. Insurance release forms and consent to treatment forms must be signed upon each admission.