

Due Date: \_\_\_\_\_

Is this your first baby?

Yes  No



**CHESAPEAKE REGIONAL  
MEDICAL CENTER**



## MATERNITY PRE-ADMISSION FORM

### Patient Information

Patient's Full Name

\_\_\_\_\_

First

Middle

Last

Maiden

Marital Status:  Single  Married  Separated  Divorced  Widowed

Race/Ethnicity:  White / Caucasian  Black / African American  Asian  Hispanic / Latino

American Indian / Alaskan Native  Native Hawaiian/Pacific Islander

\_\_\_\_\_

Street Address

City

State

Zip

How Long?

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Religious Preference \_\_\_\_\_

U.S. Citizen:  Yes  No Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Employment Information:

\_\_\_\_\_

Name of Employer

Employer Address

Work Phone

### Legal Next of Kin Information

Name of Spouse or Nearest Living Relative \_\_\_\_\_

Last

First

\_\_\_\_\_

Address (street, apt. #)

City / State / Zip

Home Phone # \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ If not spouse, relationship to you \_\_\_\_\_

\_\_\_\_\_

Spouse's Employer

Spouse's Employer Address

City

State

Zip

### History Information

Name of Physician / Obstetrician \_\_\_\_\_ Physician / OB Phone# \_\_\_\_\_

Have you previously been a patient at Chesapeake Regional Medical Center?  Yes  No Date of service(s) \_\_\_\_\_

Name, if different than current \_\_\_\_\_

Last

First

### Insurance Information

Insurance Provider \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Subscriber DOB \_\_\_\_\_ SSN \_\_\_\_\_ Employment \_\_\_\_\_

\_\_\_\_\_

Insurance Provider Address

City

State

Zip

Provider Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Provider \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Subscriber DOB \_\_\_\_\_ SSN \_\_\_\_\_ Employment \_\_\_\_\_

\_\_\_\_\_

Insurance Provider Address

City

State

Zip

Provider Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**General Information:**

- If there are any changes in your personal information before delivery, please contact the Maternity Registration Office at 757-312-6105 and choose option 2.
- This form may be hand-delivered to your physician or mailed (no postage necessary) to the hospital maternity registration office.
- Please use elevator "C" at the Garden Entrance when you arrive for service and go immediately to the 3rd floor.

**Physician Information:**

- You will be required to select a pediatrician for your baby before your arrival to the hospital and delivery. If you have not selected a physician, the on-call pediatrician will be selected for you.
- Many pediatrician offices offer a free prenatal visit for maternity patients to ensure you are comfortable with their practice.
- You will be billed separately for all services and/or consultations provided by physicians, such as the anesthesiologist, pediatrician, pathologist, radiologist and/or obstetrician.

**Financial Information:**

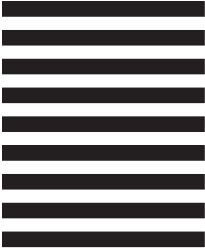
- If your insurance covers less than the full amount of your charges, you will be required to pay this self-pay balance on admission or prior to discharge.
- Financial arrangements may be made in advance by contacting the maternity registration office (312-312-6105). CRMC does offer reduced or discounted rates for those patients that meet certain financial requirements. You can discuss those discounts with a financial counselor by calling 757-312-4285.



NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES

**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL PERMIT NO. 4001 CHESAPEAKE VA

POSTAGE WILL BE PAID BY ADDRESSEE



CHESAPEAKE REGIONAL MEDICAL CENTER  
736 BATTLEFIELD BLVD N  
CHESAPEAKE VA 23320-9941  
**ATTN: MATERNITY REGISTRATION DEPARTMENT - 3RD FLOOR**

