



800 East 21st Street  
 PO Box 5045  
 Sioux Falls, SD 57117-5045  
 (605) 322-8000

# Maternity Preregistration Form

The information you supply on this form will assist with admission preregistration. The information you provide will also be used to initiate your child's birth certificate. Please follow the instructions below when completing this form:

1. Complete and submit this form as early as possible after your first prenatal visit.
2. Use only full legal names including middle names. (No initials, nicknames or shortened versions of names.)
3. Be as accurate as possible.
4. Return the form in the enclosed self-addressed stamped envelope.

You will be given an opportunity during your stay to confirm the information you have provided.

## Patient Information

Due Date: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ e-mail Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Maiden/Other Name: \_\_\_\_\_  
(last name, first name, middle name) (last name, first name, middle name)

Mailing Address: \_\_\_\_\_ County Patient Resides: \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_

Marital Status  Divorced  Married  Single  Widowed  Unknown Soc Sec # \_\_\_\_\_

Religion \_\_\_\_\_ Your Church \_\_\_\_\_

Are you open to visitation from your religious affiliation?  Yes  No

Employer \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer Phone # (\_\_\_\_) \_\_\_\_\_ Your Occupation \_\_\_\_\_

Admitting Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Family/Primary Care Physician: \_\_\_\_\_

For Continuity of Care your Medical Records may be released to your Referring and/or Family Physician.

Do you have a living will?  Yes  No

Do you have a durable power of attorney for health care?  Yes  No If yes, please bring a copy when admitted.

If you wish to create an Advance Directive prior to your delivery, call Social Services at (605) 322-8400.

If a person inquires if you're in the hospital, may we give them your room number?  Yes  No

## Next of Kin/Person to Notify

**Father of Baby** \_\_\_\_\_ Mailing Address \_\_\_\_\_  
(last name, first name, middle name)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_

**Person to Notify** \_\_\_\_\_ Mailing Address \_\_\_\_\_  
(last name, first name, middle name)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Guarantor

If patient is 18 or older and out of high school they will be listed as guarantor. If the guarantor is different please complete guarantor section.

**Person Financially Responsible (Guarantor)** \_\_\_\_\_  
(last name, first name, middle name)

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_



800 East 21st Street  
 PO Box 5045  
 Sioux Falls, SD 57117-5045  
 (605) 322-8000

# Maternity Preregistration Form

## Insurance

In order to make sure we properly bill your insurance company, it is important to fill out the following insurance information correctly. Please attach a copy of both sides of your insurance card. Some insurance companies require notification when a member becomes pregnant and immediately after the baby is born. You may need preapproval for your hospital admission through your insurance company prior to admission. Failure to do this may result in a penalty against your benefits. Please contact the customer service department of your insurance company to determine what is required.

**Primary Insurance** \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Group # \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Policy Holder SSN: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_  
 Policy # \_\_\_\_\_ Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Group # \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Policy Holder SSN: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

**Baby Insurance Information (required only if baby added to different policy than primary)**

**Primary Insurance** \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Group # \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Policy Holder SSN: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

**To assure you are preadmitted, please fax or mail this form to Avera McKennan Admissions as early in your pregnancy as possible.**

**Fax: 605-322-8296**

**You may preregister online at [www.averamckennan.org](http://www.averamckennan.org).**

**Please Note:**

\*\* Most insurance companies require infants to be added to the plan within the first 30 days. Please contact your insurance company **prior to delivery** to determine requirements for infant coverage.\*\*