Maternity Preregistration

LEGACY HEALTH

Patient Information

Due date	Referring OB provider or midwife	Baby's doctor	Primary Care doctor

Patient's legal last name	First	Middle	Former or maiden name	Date of birth

Patient's mailing address	City	State	Zip	Phone

Marital status ☐S ☐SEP ☐M ☐W ☐D	Patient's Social Security number	Patient's email address	Race	Hispanic or Latino? ☐ Yes ☐ No

Check if these apply for this pregnancy ☐ Open adoption ☐ Closed adoption ☐ Surrogacy ☐ Gestational carrier ☐ N/A	Patient's religious preference	Patient's country of birth

Patient's Employer	Phone	Extension	Occupation

Employer's street address	City	State	Zip

Insurance information for the primary policy holder

Policy holder's last name	First name	Middle initial	Date of birth	Relationship to patient	Sex

Name of primary insurance company	Policy number	Group number	Insurance phone

Insurance mailing address	City	State	Zip

Policy holder's employer *(if insurance is through employer)*	Policy holder's Social Security number	Occupation	Home or cell phone

Employer's phone	Ext

Insurance information for the secondary policy holder

Policy holder's last name	First name	Middle initial	Date of birth	Relationship to patient	Sex

Name of secondary insurance company	Policy number	Group number	Insurance phone

Insurance mailing address	City	State	Zip

Policy holder's employer *(if insurance is through employer)*	Policy holder's Social Security number	Occupation	Home or cell phone

Employer's phone	Ext

Which coverage will newborn be added to? ☐ Primary policy holder ☐ Secondary policy holder ☐ Both primary and secondary policies

Self-Pay Information

☐ If uninsured, mark here to receive a financial assistance package.	If uninsured in Oregon or Washington, have you applied for the Oregon Health Plan or Washington Medicaid? ☐ Yes ☐ No

If the person responsible for the account is someone other than the patient, the next section must be completed.

Last name (parent's name if minor)	First	Middle	Relationship	Sex	Birthdate

Responsible party's mailing address	City	State	Zip	Home phone

Responsible party's Soc. Sec. no.	Employer of person responsible for account	Occupation

Employer's street address	City	State	Zip	Phone	Ext

Whom to Notify in Emergency (spouse or nearest relative)

Last name (next of kin)	First	Middle	Relationship	Home phone

Street Address	City	State	Zip	Work or cell phone

Other emergency notification (if desired)	Relationship	Home phone

Street address	City	State	Zip	Work or cell phone

Other Information

Have you ever been a patient at Legacy Health? ☐ Yes ☐ No	If yes, was your previous medical record under another name? Please note_____