

CENTRA CARE Health Melrose

PREREGISTRATION AND BIRTH CERTIFICATE INFORMATION

Please send in this preregistration form to the hospital as soon as possible, but no later than week 28. Put in a stamped envelope and mail to CentraCare Health - Melrose, 525 Main Street West, Melrose, MN 56352. Thank you!

Estimated date of baby's birth: _____ Baby's last name will be: _____

Do you want a social security number ordered for your baby at birth? Circle: Yes No

MOTHER'S INFORMATION

Mother's legal name: First: _____ Middle: _____ Last: _____

Street address: _____ City: _____ State: _____ ZIP: _____

Mailing address (if different from above): _____ Home phone number: _____

City: _____ State: _____ ZIP: _____

County: _____ In city limits? _____ If out of city, give township: _____

Marital status: Circle: Married Single Separated Divorced Widowed

Maiden name: _____ Birthplace: _____ City: _____ State: _____ Country: _____

Date of birth: _____ Mother's social security number: _____

Race/ethnicity: _____ If Hispanic: Circle: Cuban Mexican Puerto Rican Other Latino

Preferred language: _____ Do you speak English? _____

Education (years): Primary/secondary (K-12): _____ College: _____ Technical: _____

Degree completed? Circle: Associate Bachelor Master Doctorate

Employer: _____ Phone number: _____ Address: _____

Religion: _____ Place of worship: _____

Did you participate in the WIC nutritional program during this pregnancy? Circle: Yes No

If you circled "yes," what month of the pregnancy did WIC begin (1st, 2nd, 3rd, etc.)? _____

Pre-pregnancy weight: _____ First doctor visit for pregnancy (MM/DD): _____ Cigarette use? _____ If yes, number per day: _____

Single mothers: Do you want the birth to be public information at the county courthouse? Circle: Yes No

If you circled "yes," your baby's birth will be listed in the newspaper.

CHILD'S FATHER INFORMATION

Father's name: First: _____ Middle: _____ Last: _____

Mailing address (if different from above): _____ Home phone number: _____

City: _____ State: _____ ZIP: _____

County: _____ In city limits? _____ If out of city, give township: _____

Birthplace: _____ City: _____ State: _____ Country: _____ Date of birth: _____

Father's social security number: _____ Marital status: Circle: Married Single

Race/ethnicity: _____ If Hispanic: Circle: Cuban Mexican Puerto Rican Other Latino

Education (years): Primary/secondary (K-12): _____ College: _____ Technical: _____

Degree completed? Circle: Associate Bachelor Master Doctorate

Employer: _____ Phone number: _____ Address: _____

Religion: _____ Place of worship: _____

PREVIOUS BIRTH INFORMATION

How many children are now living? _____ How many were born alive, but are now deceased? _____

How many miscarriages/stillbirths? _____ Date of last loss? _____

Date of last live birth (prior to this pregnancy): Month: _____ Year: _____

PROVIDER INFORMATION

Your provider/doctor: _____ Primary or family provider/doctor: _____
Baby's provider/doctor: _____

TWO EMERGENCY CONTACTS

Name of contact person: _____ Relationship to patient: _____
Home phone: _____ Cell phone: _____ Work phone: _____

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INSURANCE

Check appropriate space below. Please bring your insurance card with you to the hospital.

Medicare: I.D. number: _____ Coverage: Circle one: A & B A only B only

Blue Cross/Blue Shield: Policy holder's name: _____
I.D. number: _____ Group number: _____

MN Health Care Program/Medical Assistance: Number: _____

Other Insurance:

Name of insurance company: _____
Policy holder's name: _____
Policy number: _____ Group number: _____

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