Regions Hospital®
The Birth Center

Welcome to Regions Hospital Birth Center. Please complete this form to help your registration process run more smoothly. The completed form can be given to your doctor or midwife during a clinic visit.

Pre-Registration Form

Date: _____ Baby's Due Date: _____

Reason for visit: _____

Patient: _____ Birth date: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mom's Doctor or Midwife: _____ Mom's Clinic: _____

Baby's Doctor: _____ Baby's Clinic: _____

Spouse/Nearest Relative: _____ Relationship: _____

Address: _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Religion: _____ Marital status: _____ Race: _____

Ethnicity: _____ Country of Origin: _____ Language: _____

Is an Interpreter Needed? Yes or No (circle one)

Employer: _____ Work Phone: _____

Employer address: _____ City: _____ State: ____ Zip: _____

Health Insurance Information

Insurance name: _____

Group Number: _____ Policy ID: _____

Who is the person responsible for the hospital bill? Is it the patient? Yes or No (Circle one)

If no, complete the following:

Name: _____ Birth date: _____

Relationship to the patient: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Phone: _____

PLEASE COPY FRONT AND BACK OF ALL INSURANCE CARDS

Please give the completed form to you doctor or midwife. Or mail completed form to:

Patient Placement, MS 11102T, 640 Jackson Street, St. Paul, MN 55101