

# CENTRA CARE Health

## Long Prairie

### 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 – Long Prairie, 20 Ninth Street Southeast, Long Prairie, MN 56347. 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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Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_