Registration Information

Complete and return to:
Woman's Hospital/Admitting Dept.
P. O. Box 95009 • Baton Rouge, Louisiana 70895-9009 • **Fax:** (225) 924-8110
Or submit this information on our website at *www.womans.org*

PLEASE COMPLETE THIS ENTIRE FORM – Sections 1 - 5

1. GENERAL INFORMATION (Answer all questions)

Are you having surgery? ☐ Yes ☐ No **SURGERY DATE:** ____/____/____	Are you pregnant? ☐ Yes ☐ No **DUE DATE:** ____/____/____	Admitting Doctor:

While at Woman's Hospital, do you want to be included in our Hospital Phone Directory? ☐ Yes ☐ No
(If NO, remember family, friends, clergy, and florists will not be told that you're at Woman's Hospital.)
If yes to the above question, do you want to receive visits from members of your church or religion? ☐ Yes ☐ No

If pregnant, what insurance will the baby be placed on?

If having surgery, what type?

What is your primary language spoken?

Please tell us about any special hearing, physical, verbal, visual or other needs:

2. PATIENT INFORMATION

Name (last, first, middle):		Birth date (month/day/year): ____/____/____
Address: (street, apt. or lot #, city, state, zip)		
Home Phone: ( )	Cell Phone: ( )	☐ Married ☐ Single ☐ Widowed ☐ Divorced
Race:	Social Security #:	Religion:
Email Address:		
Maiden Name:	May we contact you at work if we need additional information? ☐ Yes ☐ No	
Employer's Name and Address:		
Work Phone: ( )	Occupation:	

3. EMERGENCY CONTACTS — ** Must list 2 contact persons**

1. Name of Nearest Relative (not living with patient):		Home Phone: ( )
Address: (street, apt. or lot #, city, state, zip)		Work Phone: ( )
Relationship to patient:		Cell Phone: ( )
2. Spouse/Parent's Name (last, first, middle):		Home Phone: ( )
Address (If different from patient):		Work Phone: ( )
Spouse/Parent's Social Security #:	Relationship to patient:	Cell Phone: ( )
Spouse/Parent's Employer (name and address):		

4. PRIMARY INSURANCE — **Attach Copy of the Front and Back of Your Insurance Card(s)**

Primary Insurance Name:	Primary Insurance Address: (city, state, zip)		Phone: ( )
Plan Type: (HMO, PPO, etc.)			Pre-Cert. Phone: ( )
Policy #:	Policy Holder's Name:		Group #:
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Employer:	Relationship to Patient:

5. SECONDARY INSURANCE — **Attach Copy of the Front and Back of Your Insurance Card(s)**

Secondary Insurance Name:	Secondary Insurance Address: (city, state, zip)		Phone: ( )
Plan Type: (HMO, PPO, etc.)			Pre-Cert. Phone: ( )
Policy #:	Policy Holder's Name:		Group #:
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Employer:	Relationship to Patient: