Kathleen C. Cailloux birthing center

PLEASE BRING TO ADMISSIONS OR FAX (830) 997-1401 60 DAYS PRIOR TO DUE DATE.

Main Admissions Dept.
1020 S State Hwy 16, Fredericksburg, Texas 78624
(830) 997-1301

OB PRE-REGISTRATION FORM

HOSPITAL VISIT INFORMATION *Required Field

Family Physician First and Last Name:
Ordering Physician First and Last Name:
*Scheduled Date: *(Scheduled date must be at least 2 business days in the future)*

INFORMACIÓN DEL PACIENTE

*First Name:	MI:	Last Name:
Social Security Number:	*Date of Birth:	
*Race: ❍ African American/Black ❍ Asian ❍ Caucasian ❍ Native American/Alaskan ❍ Pacific Islander ❍ Other:		
*Ethnicity: ❍ Hispanic/Latino or Spanish ❍ **NO,** not Hispanic/Latino or Spanish	*Preferred Language:	Religion:
*Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Life Partner ❍ Legally Separated		
*Address:	*City	
*State	*Zip	
*Home Phone	Other Phone	
*Is Patient Currently Employed? ❍ Yes ❍ No	*If so, list employer:	

NEXT OF KIN INFORMATION ❍ Next of kin has international address

*First Name:	Middle Initial:	Last Name:
Same Address as Patient? ❍ Yes ❍ No		
*Address	*City:	
*State	*Zip	
*Home Phone:	Work Phone:	
*Relation to Patient:		

NOTIFY IN CASE OF EMERGENCY ❍ Same as next of kin

*First Name:	Middle Initial:	Last Name:
Same Address as Patient? ❍ Yes ❍ No	Emergency contact has an International Address? ❍ Yes ❍ No	
*Address	*City:	
*State	*Zip	
*Home Phone:	Work Phone:	
*Relation to Patient:		

Kathleen C. Cailloux birthing center

PLEASE BRING TO ADMISSIONS OR FAX (830) 997-1401 60 DAYS PRIOR TO DUE DATE.

Main Admissions Dept.
1020 S State Hwy 16, Fredericksburg, Texas 78624
(830) 997-1301

OB PRE-REGISTRATION FORM

INSURANCE INFORMATION

Does patient currently have insurance? ❍ Yes ❍ No

RESPONSIBLE PARTY INFORMATION

Who is the responsible party? ❍ Patient ❍ Spouse ❍ Dependent ❍ Parent/Guardian

INFORMACION DE SEGURO

*Primary	Secondar:
Policy #:	Policy #:
Group #:	Group #:
Subscriber: (if different from patient)	Subscriber: (if different from patient)
D.O.B. / SSN	D.O.B. / SSN

❍ Favor de enviar copia de su tarjeta de seguro – Frente y Reverso

EMAIL NOTIFICATION

Would patient like to receive email notifications? ❍ Yes ❍ No	Email Address:

ADDITIONAL COMMENTS: