*We are so excited you decided to have you baby at a Vidant Health Hospital. Thank you for allowing us to care for you and your family during this special event. Please complete this registration form prior to your 24th week of pregnancy and return via mail or fax as noted above. We look forward to seeing you***!**

**Estimated Due Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hospital delivering your baby** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle/Maiden**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status:** Single/Married/Divorced/Widowed

**Mailing Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State/Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State/Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Race** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic Group:** Non-Hispanic/Hispanic/Other **Preferred/Primary Language** \_\_\_\_\_\_\_\_\_\_\_ **Need Interpreter:**  Yes/No

**Employment Status:** Full-time/Part-time/Retired/Self-Employed/Disabled/Active military/Student/Minor/Not Employed

**Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have an Advanced Directive or Living Will?**  Yes/No, if yes please provide us with a copy

**Do you have a Financial and or Medical Power of Attorney?**  Yes/No, if yes please provide us with a copy

***Maternity Information***

**Date of Last Menstrual Period \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are you expecting multiple babies,** Yes/No

**Obstetric Provider** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Obstetric Provider Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Provider** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Provider Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please turn over to complete and sign the back of this form**

***Insurance Information* – please provide copies of your insurance card/cards**

**Primary Insurance company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber’s name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber’s date of birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to patient** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber’s name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber’s date of birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to patient** \_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to

the physician. I understand that I am financially responsible for any balance. I also authorize payment of all medical benefits which are payable to me under the terms of my insurance policy to be paid directly to the above named physician for services rendered.

**Signature of patient/guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time**\_\_\_\_\_\_\_\_\_