Henry County Health Center
407 S. White ▪ Mt. Pleasant, Iowa 52641-2242 ▪ (319)385-3141
www.hchc.org

Maternity Services Pre-Admission Registration

Please complete the following information before admission to HCHC. You may leave this form at the HCHC Admissions Desk for pre-registration. *(Also, if your insurance company requires pre-approval, please notify them immediately of your anticipated date of admission and include their approval number below.)*

Patient's Name ______________________________

Address ______________________________

Phone # ______________________________

If patient is a minor, first name of parents:

Father ______________________________

Mother ______________________________

Guarantor's (person responsible for payment) Name ______________________________

Address ______________________________

Phone # ______________________________

Social Security # ______________________________

Relationship to Patient: ______________________________

Guarantor's Employer:

Name ______________________________

Address ______________________________

Patient's Employer:

Name ______________________________

Address ______________________________

Patient's Insurance Carrier: ____________________

Spouse's Insurance Carrier: ____________________

Which insurance is primary (who pays 1st? —see below *) ____________________

Were you ever here under a different last name? If so, please state name: ____________________

Planned Date of Admission ____________________

Attending Physician ____________________

Baby's Physician ____________________

Patient's Date of Birth ______________ **Age** ______

Sex _____ **Race** __________ **Marital Status** _______

Social Security # ____________________

Church Preference ____________________

Have you ever been a patient at HCHC before? Dates ____________________

Emergency contact/Next of kin:

Name ____________________

Address ____________________

Phone ____________________

Relationship to Patient ____________________

Does your insurance company require pre-approval for obstetric admission and/or 24 hour notification following delivery of your baby? ________ yes ________ no

Has this approval been obtained? ________ Insurance approval # ______________________________

*As of January, 1986, if husband and wife have family coverage with separate employers, dependent children are covered by the insurance of the parent whose birthdate is the first in the calendar year.

Mother's birthdate ______________________ Father's birthdate ______________________

If you have any questions regarding insurance benefits or pre-certification requirements, please contact HCHC Patient Accounting at 319-385-6142 or the Patient Care Review Coordinator at 319-385-6126. Thank you!

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