OB Pre-Registration Information Sheet

Sonoran Crossing Medical Center
33400 North 32nd Ave
Phoenix, AZ 85085
623-683-5060
Admitting.SonoranOB@Honorhealth.com

Shea Family Birthing Center
9003 E Shea Blvd
Scottsdale, AZ 85260
480-323-3331
Admitting.SheaOB@HonorHealth.com

Submit **completed application** along with **photo ID** and **Front/Back of insurance card** to the facility of choice listed above.

Important Reminders

Please check with your **benefits department** in advance to find out the rules they have in place about enrolling newborns on parent's health insurance. Rules vary depending on the employer and the insurance carrier, so it is important to contact them immediately.

If the newborn will have coverage under both parents, the **Birthday Rule** would be in effect meaning the primary coverage for the child would be the insurance carrier of the parent born earlier in the calendar year (birth year is not considered for the birthday rule).

If mother is already enrolled in **AHCCCS** (Arizona Medicaid) the mother needs to contact the AHCCCS plan to add baby. ***If you would like to apply for yourself or your newborn, please contact the Admitting Dept. for assistance.***

Additional Resources

Patient portal: honorhealth.com/patients-visitors/mychart-patient-portal

Preparing to have your baby: honorhealth.com/medical-services/maternity/preparing-for-baby

Contracted Insurance Plans: https://www.honorhealth.com/patients-visitors/insurance

Financial Assistance: https://www.honorhealth.com/patients-visitors/financial-assistance-policy

Visitor guidelines: https://www.honorhealth.com/visitor-restrictions

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OB PRE-REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____First Name: _____ Middle Initial: _____

Have you ever been seen in an HonorHealth facility under a different name? _____

Social Security Number: _____ Date of Birth: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed

The State of Arizona requires hospitals to report various data on patients including race and ethnicity

Ethnicity	
☐ Not Hispanic/Latino	
☐ Hispanic/Latino	

Race		
☐ Native American	☐ Asian	☐ White
☐ Middle Eastern	☐ Black/African American	☐ Hawaiian/Pacific Islander

Primary language spoken: ☐ English ☐ Spanish ☐ Other_____

Would you like to list a religious preference? _____

Patient's Maiden name: _____ Mother's Maiden name:_____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Primary Phone: _____-_____-_____ Secondary Phone: _____-_____-_____

If you are here visiting or provided a PO Box:

What is your local address? _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Patient Employment Information

Employment Status	
☐ Full Time	☐ Part Time
☐ Unemployed	☐ Self Employed
☐ Retired _____ Date of Retirement	☐ Disabled _____ Date of Disability

Employer Information
Current Employer _____
Occupation _____

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Important Birth/Provider Information (PLEASE FILL OUT FORM COMP

Which campus do you intend to utilize for delivery? ☐ Shea ☐ Sonoran

Date of last menstrual period: _____/_____/_____ Estimated Due Date: _____/_____/_____

Obstetrician (OB-GYN) Last Name: _____ First Name: _____

Primary Care Physician Last Name: _____ First Name: _____

Do you have a Pediatrician for the baby? ☐ Yes ☐ No ☐ Unsure ☐ I will before birth

If yes, pediatrician's Last Name: _____ First Name: _____

Enrollment in a clinical trial: ☐ Currently Enrolled ☐ Previously Enrolled ☐ Never Enrolled

Preferred Pharmacy (Name and Location): _____

Spouse or Parent of Minor/Emergency Contact

Last Name: _____ First Name:_____

☐ Spouse ☐ Mother ☐ Father ☐ Guardian Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address (if different than patient): _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact Information

Primary Contact Last Name: _____ Primary Contact First Name:_____

Relationship: _____ Phone: _____

Secondary Contact Last Name: _____ Secondary Contact First name:_____

Relationship: _____ Phone: _____

Employment Information for Spouse OR Guardian of minor/ Insurance Information

Employment Status	
☐ Full Time	☐ Part-time
☐ Unemployed	☐ Self Employed
☐ Retired_____ Date	☐ Disabled _____ Date

Employer Information
Current Employer: _____
Occupation: _____

Primary Insurance

Insurance Carrier: _____ Name of Insured: _____

Policy Number: _____ Group Number: _____ DOB: _____ Ins. Phone: (_____) _____-_____

Will your newborn have insurance through this same plan? ☐ **Yes** ☐ **No**

Secondary Insurance *(If Applicable):*

Insurance Carrier: _____ Name of Insured: _____

Policy Number: _____Group Number: _____ DOB:_____ Ins. Phone: (_____) _____-_____