OB Pre-registration form

Thank you for choosing HonorHealth. To ensure that we identify you correctly and our records are accurate, please fill out this form completely. If you have any questions about the information being asked on this form or need assistance in completing this form, please do not hesitate to contact the registration staff.

Where do you plan to deliver your baby? Osborn ☐ Shea ☐

Osborn Family Birthing Suites
3624 N. Wells Fargo Ave.
Scottsdale, AZ 85251
480-882-4018
Admitting.OsbornOB@HonorHealth.com

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

Patient information

First name_____ Last name _____ Middle initial_____

Social security number _____-_____-_____ Date of birth_____ /_____ / _____

Have you been seen at any HonorHealth facility under a different name? No ☐ Yes ☐
If "Yes", what name was used? _____

Your baby's estimated due date _____ /_____ / _____

Your obstetrician (Ob-Gyn): First name_____ Last name_____

Your street address: _____

City_____ State_____ Zip code_____

Phone numbers Cell: _____ Home: _____

Your email address: _____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Have significant other

Religious preference: _____ ☐ I prefer not to answer.

Do you have any hearing impairments? No ☐ Yes ☐

Have you ever participated in a clinical trial? No ☐ Yes ☐

The U.S. government requires HonorHealth to ask the following two questions. You aren't required to provide a response.

Ethnicity	Race
☐ Hispanic or Latino	☐ White/Caucasian ☐ Black/African American ☐ Asian
☐ Not Hispanic or Latino	☐ American Indian ☐ Pacific Islander ☐ Prefer not to answer

What is your primary language? _____ Interpreter required? No ☐ Yes ☐

Who is your primary care doctor? First name_____ Last name_____

What is your **employment status**?

Employment status	Employer information
☐ Full time ☐ Part time	Current employer:
☐ Self-employed ☐ Student	_____
☐ Minor ☐ Other: _____	Occupation:
	_____

Who would you like to list as an **emergency contact**?

First name_____ Last name_____

City_____ State_____ Zip code_____

Phone number/Cell: _____ Relationship to you: _____

What is the name of **your health insurance** provider/company?

Name: _____

Member/ Policy Number: _____ Group Number: _____

Claims Address: _____

Insurance Phone Number: _____

Relationship of the primary subscriber to you:

☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Is your insurance through your employment? No ☐ Yes ☐

If "**Yes**"
How many employees work at your company?
☐ 1 to 19 ☐ 20 to 99 ☐ 100 or more ☐ I don't know.

What is the name of your employer? _____

Subscriber information

First name _____ Last name _____

Social security number _____-_____-_____ Date of birth_____ /_____ / _____

Street address _____

City_____ State_____ Zip code_____

Phone Number (cell):_____

Is the insurance through their employment? No ☐ Yes ☐

If "**Yes**"
How many employees work at their company?
☐ 1 to 19 ☐ 20 to 99 ☐ 100 or more ☐ I don't know.

What is the name of their employer? _____

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

Do you have any additional Insurance? No ☐ Yes ☐

Please complete all three pages of this form. Email your completed pre-registration form AND clear front and back copies of your insurance card(s) to the HonorHealth admitting team at the hospital where you plan to deliver.

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