| Sonoran Crossing Medical Center | Osborn Family Birthing Suites | Shea Family Birthing Center |
|---|---|---|
| 33400 North 32nd Ave | 3624 N Wells Fargo Ave | 9003 E Shea Blvd |
| Phoenix AZ 85085 | Scottsdale, AZ 85251 | Scottsdale, AZ 85260 |
| 623-683-5060 | 480-882-4018 | 480-323-3331 |
| Admitting.SonoranOB@Honorhealth.com | Admitting.OsbornOB@HonorHealth.com | Admitting.SheaOB@HonorHealth.com |

# OB PRE-REGISTRATION FORM

Thank you for choosing Honor Health. 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 for on this form or need assistance in completing this form please do not hesitate to contact the registration staff.

## 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____________________ Mothers Maiden name: ________________________

Mailing Address ____________________________________________________________________________ Apt/Unit _______________

City __________________________________________________________ State _______________ Zip Code _______________________

If you are here visiting or provided a PO Box: What is your local address?

_________________________________________________ City ________________________ State _______ Zip Code _______________

Primary Phone ______-_______-_________ Secondary Phone ______-________-_________ Confidential? ☐ Yes ☐ No

Email Address _______________________________________________________________

**Patient Employment Information**

| Employment Status | |
|---|---|
| ☐ Full Time | ☐ Part Time |
| ☐ Not Working | ☐ Self Employed |
| ☐ Retired _____________ Date of Retirement | ☐ Disabled ____________ Date of Disability |

| Employer Information |
|---|
| Current Employer ____________________________________ |
| Occupation _________________________________________ |

**PLEASE FILL OUT FORM COMPLETELY** (continue on the backside of this form)

**Important Birth/Provider Information (PLEASE FILL OUT FORM COMPLETELY)**

Which campus do you intend to utilize for delivery? ☐ Osborn ☐ 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): ______________________________________________________________

Would you like to list a religious preference? if so, please state ______________________________________________

**Spouse or Parent of Minor/Emergency Contact**

Last Name ______________________________________________ First Name ______________________________________________

☐ Spouse ☐ Mother ☐ Father Date of Birth _____/_____/________ SSN ______-______-________

Address (if different than patient) ______________________________________________________________

City ______________________________________________ State ___________ Zip Code ______________________________

Primary Phone ______________________________________ Secondary Phone ______________________________________

**Employment Information for Spouse OR Parent of Minor**

| Employment Status | | Employer Information |
|---|---|---|
| ☐ Full Time | ☐ Part Time | Current Employer ______________________________________ |
| ☐ Not Working | ☐ Self Employed | Occupation ______________________________________ |
| ☐ Retired _____________ Date of Retirement | ☐ Disabled ___________ Date of Disability | |

**Emergency Contact Information**

| Primary Contact | Secondary Contact |
|---|---|
| Last Name ______________________________________ | Last Name ______________________________________ |
| First Name ______________________________________ | First Name ______________________________________ |
| Relationship ______________________________________ | Relationship ______________________________________ |
| Phone ______________________________________ | Phone ______________________________________ |

**Insurance Information**

**Primary Insurance:**

Insurance Carrier: ______________________________________________ Who is the Primary 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: ______________________________________________ Who is the Primary Insured: ____________________________

Policy Number: ______________________________ Group Number: ____________ DOB:___________ Ins Phone: (______) _____-________