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

Osborn Family Birthing Suites
3624 N Wells Fargo Ave
Scottsdale, AZ 85251
480-583-0326
Admitting.OsbornOB@HonorHealth.com

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

OB PRE-REGISTRATION FORM

(PLEASE FILL OUT ALL FORMS COMPLETELY)

EXPECTED DUE DATE: _____/_____/_____

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: _____/_____/_____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

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

Email Address: _____

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

Would you like to list a religious preference? _____

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_____

Preferred Pharmacy (Name and Location): _____

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

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

Patient Employer Information
Current Employer _____
Occupation _____

HONORHEALTH

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Provider Information

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

Primary Care Physician Last Name: _____ First Name: _____ ☐ None

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

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

Emergency Contact Information

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

Relationship: _____ Phone: _____

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

Relationship: _____ Phone: _____

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

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

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

Spouse or Parent of Patient (if a Minor) Information

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: _____

Employment Information for Spouse or Parent of Patient (if a Minor)

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

Employer Information

Current Employer _____

Occupation _____

HONORHEALTH

(PLEASE FILL OUT ALL FORMS COMPLETELY)

Primary Insurance

Insurance Carrier: _____ Name of Insured: _____

Policy Number: _____ Group Number: _____

Subscriber DOB: ____/_____/_____ Ins. Phone: (_____) _____-_____

Is this coverage through employment: ☐ YES ☐ NO

Is the Patient the Main Subscriber: ☐ YES ☐ NO

If "**NO**":

Main Subscriber Name: _____ Main Subscriber DOB: _____/_____/_____

Relationship to Patient: _____

Secondary Insurance *(If Applicable):*

Insurance Carrier: _____ Name of Insured: _____

Policy Number: _____ Group Number: _____

Subscriber DOB: ____/_____/_____ Ins. Phone: (_____) _____-_____

Is this coverage through employment: ☐ YES ☐ NO

If "**NO**":

Main Subscriber Name: _____ Main Subscriber DOB: _____/_____/_____

Relationship to Patient: _____

Is this coverage through employment: ☐ YES ☐ NO

IMPORTANT REMINDER REGARDING YOUR NEWBORN'S INSURANCE COVERAGE

Whose insurance do you plan on adding the baby to?

☐ **Mom** ☐ **Dad** ☐ **Other (Name/relationship) _____**

Newborns cannot be added to the grandparent's group health insurance policy unless they have legal guardian rights.

Primary Insurance *(If Applicable):*

Insurance Carrier: _____

Name of Insured: _____

Policy Number: _____Group Number: _____

DOB: _____ Ins. Phone: (_____) _____-_____

Secondary Insurance *(If Applicable):*

Insurance Carrier: _____

Name of Insured: _____

Policy Number: _____Group Number: _____

DOB: _____ Ins. Phone: (_____) _____-_____

We suggest you check with your benefits department in advance to find out the rules they have in place about enrolling newborns on their 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 child 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. The birth year is not considered for the birthday rule.

If the mother is already enrolled in AHCCCS, (Arizona Medicaid), the mother needs to contact the AHCCCS plan to add the baby. ***If you would like to apply for yourself or your newborn, please contact the Admitting Dept. for assistance: 480-583-0326 for Osborn, 480-323-3331 for Shea, and 623 683-5060 for Sonoran.***

Please send this form, a copy of your insurance card and photo ID to Admitting.SheaOB@HonorHealth.com