

OB Pre-Registration Information Sheet

Four Peaks Medical Center

1301 S. Crismon Road

Mesa, AZ 85209

480-358-6694

FPMCASIC@honorhealth.com

Sonoran Crossing Medical Center

33400 N. 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 **Birthdate 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](https://www.honorhealth.com/patients-visitors/mychart-patient-portal)

Preparing to have your baby: [honorhealth.com/medical-services/maternity/preparing-for-baby](https://www.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>

OB PRE-REGISTRATION FORM



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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
<input type="checkbox"/> Not Hispanic/Latino
<input type="checkbox"/> Hispanic/Latino

Race		
<input type="checkbox"/> Native American	<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Black/African American	<input type="checkbox"/> 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	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Self Employed
<input type="checkbox"/> Retired _____ Date of Retirement	<input type="checkbox"/> Disabled _____ Date of Disability

Employer Information
Current Employer _____
Occupation _____

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

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

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: _____

**check with pediatrician office to confirm they are contracted with your health insurance plan*

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	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part-time
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Self Employed
<input type="checkbox"/> Retired _____ Date	<input type="checkbox"/> 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: (_____) _____ - _____