HonorHealth.com

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

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 SHC facility under a different name? ____

Social Security Number _______________________ Date of Birth _______/_______/_________ ☐ Male ☐ Female

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

Nationality ____ Which STATE was the patient born in? ____________________________

Primary language spoken: ☐ English ☐ Spanish ☐ Other____________________________

Do you have any hearing impairments: ☐ No ☐ Yes, I would like to use the following method for interpretation
☐ Family/Friend ☐ Interpreter ☐ Video ☐ No services requested

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
May we leave a message? ☐ Yes ☐ No

Email Address ____

Patient Employment Information

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

Employer Information
Current Employer ______________________________________
Occupation ____
Work Phone ____

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

Date of last menstrual period: _______/_______/_________ Estimated Due Date: _______/_______/_________

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

Do you have a Primary Care Physician? (Family Practicioner or Internal Medicine) ☐ Yes ☐ No ☐ Unsure

If Yes, PCP's 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

Do you have a Patient Health Record with Relay Health? ☐ Yes ☐ No *Please visit our website at honorhealth.com for more information*

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

****On visits that you stay over night, you may receive a visit from our clergy or faith representative****

Spouse or Parent of Minor

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

Employer Information
Current Employer ______________________________________
Occupation ______________________________________

Emergency Contact Information

Primary Contact
Last Name ______________________________________
First Name ______________________________________
Relationship ______________________________________
Phone ______________________________________

Secondary Contact
Last Name ______________________________________
First Name ______________________________________
Relationship ______________________________________
Phone ______________________________________

Insurance Information

Primary Insurance

Insurance Carrier: ____ Who is the Primary Insured: _____________________________

Policy Number: ______________________________ Group Number: _______________ Ins Phone: (______) _____-________

Secondary Insurance (If Applicable)

Insurance Carrier: ____ Who is the Primary Insured: _____________________________

Policy Number: ______________________________ Group Number: _______________ Ins Phone: (______) _____-________