HONORHEALTH

HonorHealth.com

Osborn Campus
7400 E Osborn Road
Scottsdale, AZ 85255
480-882-6200

Shea Campus
9003 E Shea Blvd
Scottsdale, AZ 85260
480-323-3000

OB PRE-REGISTRATION FORM

Thank you for choosing Scottsdale Healthcare. 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 continue on the backside of this form

Important Birth/Provider Information (PLEASE FILL OUT COMPLETELY)

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

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

Do you have a Primary Care Physician? (Family Practitioner or Internal Medicine) □ YES □ NO □ UNSURE

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

Do you have a Pediatrician for the baby? (Please mark one) □ 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 shc.org for more information

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

****In the event that you are not discharged from the Labor and Delivery today, 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: _____ Primary Insured: _____

Policy Number: _____ Group Number: _____ Ins Phone: (_____) ____- _____

Secondary Insurance (If Applicable)

Insurance Carrier: _____ Primary Insured: _____

Policy Number: _____ Group Number:_____ Ins Phone: (_____) ____- _____