PLEASE PRINT OR TYPE COMPLETE INFORMATION AND RETURN WITHIN 24 HRS

OB/GYN Practice	Due Date (MM/DD/YY)

PATIENT

Patient Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YY)
Maiden or Other Name Used		Primary Care Provider	
Physical Address City, State, Zip Code			
Mailing Address City, State, Zip Code			
Primary Phone Number		Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other
Secondary Phone Number		Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other
Primary Language	Marital Status	Religion	Race
Ethnicity	Does the patient have a Latex allergy? ❑ Yes ❑ No		Is Patient a Veteran? ❑ Yes ❑ No
Employer			Employer Phone
Employer Address City, State, Zip Code			
Does Patient have an Advance Directive? ❑ Y ❑ N			Does the hospital have a copy? ❑ Yes ❑ No

GUARANTOR

Person accepting Financial Responsibility (if Other than Patient)		Relationship to Patient
Mailing Address City, State, and Zip Code		
Primary Phone Number	Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other
Secondary Phone Number	Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other

CONTACT

Emergency Contact (Last, First, Middle Initial)		Relationship to Patient
Physical Address City, State, Zip Code		
Primary Phone Number	Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other
Secondary Phone Number	Can we leave a message? ❑ Yes ❑ No	Phone Type: ❑Cell Phone ❑Home Phone ❑Other
Can we share your private medical information with this person? ❑ Yes ❑ No		

INSURANCE

Primary Insurance Name	Policy Number	Group Number
Mailing Address City, State, Zip Code		
Subscriber's Name (Last, First, Middle Initial)		Subscriber's Date of Birth
Will Newborn be covered under Mother's insurance? ❑ Yes ❑ No If no, please specify		
Secondary Insurance Name	Policy Number	Group Number
Mailing Address City, State, Zip Code		
Subscriber's Name (Last, First, Middle Initial)		Subscriber's Date of Birth

Wentworth−Douglass Hospital

PRE−REGISTRATION FORM

EL0040

8241−45MR
Rev. 08/04/15

NOTE: Please call your insurer for necessary pre−certification of Hospital stay/Procedure. In order for your admission to WDH to be handled as effectively as possible, please call the Pre−Registration Dept. at 740.2493 with any changes to this information.