As part of the preregistration process, we would like to send you information via unencrypted email about how to prepare for your delivery and what to expect when you go into labor and arrive at the hospital. The security and confidentiality of email communications cannot be guaranteed. By providing your email address, you are accepting the risks associated with email communications including, but not limited to: misaddressed/misdirected messages, shared email accounts, messages forwarded, stored, altered and/or copied by unintended recipients; and employers and online services that archive and inspect information transmitted through their systems. If you do not wish to receive unencrypted emails from us, please do not include your email address on the form below.

Pre-registration (with this form) is encouraged to save you precious time at check-in when you are in labor. Upon arrival at the hospital, patients must register to check that all personal and medical information is correct.

Howard County Medical Center

OB Pre-Registration Form

Please return the completed form to:
Howard County Medical Center
Admitting/Registration
5755 Cedar Lane, Columbia, MD 21044

Obstetrician or OB/GYN Office

Due Date

Primary Care Physician

Last Menstrual Cycle

PATIENT INFORMATION (Mother)

Last Name | First | Middle Initial

Maiden | Date of Birth / / | Marital Status M S W D SEP

SSN - - | Race | Ethnicity

Primary Language | Religion | Affiliation

Address

City | County | State | Zip

Ph (Home) | (Work) | (Cell)

Occupation | Email

Employer | Status: FT PT UN SELF

Employer Address

City | County | State | Zip

Do you have a living will and/or medical POA? Y (Provide copy) N | US citizen Y N

Pediatrician Selected

NEXT OF KIN/EMERGENCY CONTACT (Other than spouse)

Last Name | First | Middle Initial

Address

City | County | State | Zip

Ph (Home) | (Work) | (Cell)

Relation to patient | Email

SPOUSE INFORMATION ☐ Father of Baby

Last Name | First | Middle Initial

Date of Birth / / | SSN - - | Race | US citizen Y N

This form is also available online at hopkinshoward.org

SPOUSE INFORMATION CONTINUED

Address

City | County | State | Zip

Ph (Home) | (Work) | (Cell)

Occupation | Email

Employer | Status: FT PT UN SELF

Employer Address

City | County | State | Zip

INSURANCE INFORMATION

Primary

Primary Policyholder Name

Date of Birth / / | Race | Marital Status M S W D SEP

SSN - - | US citizen Y N | Sex M F

Occupation

Employer | Status: FT PT UN SELF

Employer Address

City | County | State | Zip

Insurance Company Name | Phone #

Policy/ID/Member # | Group #

Claims Address

City | County | State | Zip

Will Child be Added to the Same Health Insurance Plan that the Mother is Enrolled in? Y N
If No, please complete the policy information below:

Child's Policyholder Name

Insurance Company Name | Ph

Policy/ID/Member # | Group #

Secondary

Secondary Policyholder Name | DOB / / | SSN - -

Occupation

Employer | Status: FT PT UN SELF

Employer Address

City | County | State | Zip

Insurance Company Name | Phone #

Policy/ID/Member # | Group #

Claims Address

City | County | State | Zip

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD(S)