As part of the preregistration process, we would like to send you information via unencrypted e-mail 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 e-mail communications cannot be guaranteed. By providing your e-mail address, you are accepting the risks associated with e-mail communications including, but not limited to: misaddressed/misdirected messages, shared e-mail 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 e-mails from us, please do not include your e-mail address on the form below.

Preregistration (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.

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

OB Pre-Registration Form

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 | E-mail

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 | E-mail

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 hcgh.org

SPOUSE INFORMATION CONTINUED

Address

City County State Zip

Ph (Home) (Work) (Cell)

Occupation E-mail

Employer Status: FT PT UN SELF

Employer Address

City County State Zip

INSURANCE INFORMATION

Primary

Primary Policy Holder 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 Policy Holder Name

Insurance Company Name Ph

Policy/ID/Member # Group #

Secondary

Secondary Policy Holder 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)