

**Complete and Return**  
**Fax: (678) 474-7222**  
**Email:**  
**EJCHinfo@emory.edu**

## Labor & Delivery Pre-Registration Form

|                     |  |                             |                                      |                                      |                                  |                         |  |   |
|---------------------|--|-----------------------------|--------------------------------------|--------------------------------------|----------------------------------|-------------------------|--|---|
| PATIENT INFORMATION | Circle One:<br>C-Section      Induction  |                             | Expected Date of Delivery - REQUIRED |                                      | <b>INSTRUCTIONS</b>              |                         |  |   |
|                     | OB/GYN Physician   |                             |                                      |                                      |                                  |                         |  | <ul style="list-style-type: none"> <li>Patient name should be the same as it appears on Driver's License</li> <li>Please provide copy of driver's license and insurance card with this form.</li> </ul> |
|                     | Primary Care Physician   |                             |                                      |                                      |                                  |                         |  |   |
|                     | Patient's Name (Last)  |                             | (First)                              | (Middle)                             | Date of Birth                    | Age                     | <input type="checkbox"/> Single <input type="checkbox"/> Divorced<br><input type="checkbox"/> Married <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated |   |
|                     | Home Address   |                             |                                      | City                                 | State                            | Zip Code                | Country  |   |
|                     | Home Phone   |                             |                                      | Cell Phone                           | Patient's Social Security Number |                         |  |   |
|                     | E-mail   |                             |                                      |                                      | Religious Preference             |                         |  |   |
| EMERGENCY           | If you have an Advance Directive – please provide to registration at time of check in. |                             |                                      |                                      |                                  |                         |  |   |
|                     | Nearest Relative at Different Address  |                             | Relationship                         | Address                              | Phone Number                     |                         |  |   |
|                     | Notify in Case of Emergency  |                             | Relationship                         | Address                              | Phone Number                     |                         |  |   |
|                     | Insurance Company Name   |                             |                                      | Name As It Appears on Insurance Card |                                  |                         |  |   |
| INSURANCE           | Policy One   | Policy Number               | Insurance Company and Address        |                                      | Policy Holder Name               | Relationship to Patient |  |   |
|                     |  | Policy Holder Date of Birth | Policy Holder SSN                    | If Group Policy, Name of Employer    |                                  | Employer's Phone        |  |   |
|                     | Policy Two   | Policy Number               | Insurance Company and Address        |                                      | Policy Holder Name               | Relationship to Patient |  |   |
|                     |  | Policy Holder Date of Birth | Policy Holder SSN                    | If Group Policy, Name of Employer    |                                  | Employer's Phone        |  |   |
|                     | Policy Three   | Policy Number               | Insurance Company and Address        |                                      | Policy Holder name               | Relationship to Patient |  |   |
|                     |  | Policy Holder Date of Birth | Policy Holder SSN                    | If Group Policy, Name of Employer    |                                  | Employer's Phone        |  |   |