DMC
DETROIT MEDICAL CENTER

PRE-REGISTER FOR YOUR VISIT

To expedite and help us plan your admission, please complete and return this form to the birthing center.

PATIENT **PTID: (for hospital use only)**_____

_____(_____)_____
Name (Last, First) Date of Birth Home/Mobile Phone #

_____
Address City State Zip Email Address

_____M/S/D/W/Other_____
Social Security # Marital Status Religion Preferred Pharmacy (Name, Address/City, Phone #)

Who is your primary care physician?_____Do you want this physician notified of your admission? Y☐N☐

_____
Employer Address of Employer Phone #

Patient Directory Options:☐LISTED☐RESTRICTED☐UNLISTED Ethnicity_____Preferred Language_____

EMERGENCY CONTACT

_____(___)_____(___)_____
Name Relationship Home Phone # Work Phone #

PRIMARY INSURANCE COMPANY
Will you be adding newborn to this policy Y☐ N☐ (child must be added within 30 days of birth)

_____
Name of Insurance Group # ID/Policy #

_____(___)_____
Address (if other than BCBS, Medicare, Medicaid, HAP, PPOM, Omnicare/Coventry, DMC Care) Phone #

_____
Policyholder's Name Relationship DOB Social Security #

_____(___)_____(___)_____
Policyholder's Address Home Phone # Work Phone #

_____
Policyholder's Employer, Address, Phone #

SECONDARY INSURANCE COMPANY
Will you be adding newborn to this policy Y☐ N☐ (child must be added within 30 days of birth)

_____
Name of Insurance Group # ID/Policy #

_____(___)_____
Address (if other than BCBS, Medicare, Medicaid, HAP, PPOM, Omnicare/Coventry, DMC Care) Phone #

_____
Policyholder's Name Relationship DOB Social Security #

_____(___)_____(___)_____
Policyholder's Address Home Phone # Work Phone #

_____
Policyholder's Employer, Address, Phone #

MATERNITY PATIENTS ONLY
Estimated Delivery Date_____OB Physician_____Pediatrician_____
Newborn Ethnicity _____ Newborn Preferred Language_____
Do you have an Advance Directive for Healthcare (Living Will)? Y☐ N☐