



- Aurora Medical Center, Hartford
- Aurora Sinai Medical Center
- Aurora Women's Pavilion

### OB PRE-ADMISSION FORM

**\*PLEASE PRINT**

<b>PATIENT INFORMATION</b>		DUE DATE:
NAME: (Last, First, Mi)		SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:
CITY:		PHONE:
STATE:		ZIP CODE:
MARITAL STATUS:	MAIDEN / FORMER NAME:	PRIMARY LANGUAGE SPOKEN:

PER FEDERAL LAW, PLEASE DESIGNATE YOUR RACE AND ETHNICITY

**RACE:**

- AMERICAN INDIAN OR ALASKAN NATIVE
- ASIAN OR PACIFIC ISLANDER
- BLACK
- CAUCASIAN
- OTHER
- UNKNOWN / CHOOSE NOT TO ANSWER

**ETHNICITY:**

- HISPANIC ORIGIN
- NOT OF HISPANIC ORIGIN
- UNKNOWN / CHOOSE NOT TO ANSWER

OB DOCTOR:

EMPLOYER:	OCCUPATION:	
EMPLOYER ADDRESS:	LENGTH OF EMPLOYMENT:	EMPLOYMENT STATUS: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> UNEMPLOYED
CITY:	STATE:	ZIP CODE:

DO YOU HAVE A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE?  Yes  No IF YES, PLEASE ATTACH OR BRING COPY WITH YOU.

ALLERGIES <input type="checkbox"/> Yes <input type="checkbox"/> No	RELIGION:	PLACE OF WORSHIP:
RELIGION OF BABY:		

PEDIATRICIAN:

**PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL ARRANGEMENTS**  Spouse  Parent  Other  Self  
If "Self", complete information below for nearest relative.

NAME: (Last, First, Mi)		SOCIAL SECURITY NUMBER:	DATE OF BIRTH:
ADDRESS:		PHONE:	
CITY:		STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:		RELATIONSHIP (complete if other than spouse or parent):	
EMPLOYER:		OCCUPATION:	
EMPLOYER ADDRESS:			
CITY:		STATE:	ZIP CODE:
LENGTH OF EMPLOYMENT		EMPLOYMENT STATUS: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> UNEMPLOYED	

**PERSON RESPONSIBLE FOR BABY'S FINANCIAL ARRANGEMENTS**

NAME :	RELATIONSHIP
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**INSURANCE INFORMATION**    *\*If possible, please attach a copy (front and back) of your insurance card.*

PRIMARY	SECONDARY
NAME AND ADDRESS OF INSURANCE: (If on card)	NAME AND ADDRESS OF INSURANCE: (If on card)
SUBSCRIBER/POLICY HOLDER:	SUBSCRIBER/POLICY HOLDER:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
SUBSCRIBER NUMBER:	SUBSCRIBER NUMBER:
GROUP NUMBER:	GROUP NUMBER:
GROUP NAME:	GROUP NAME:

**PERSON TO CONTACT:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

- NOTE:** 1. Some insurance companies require pre-certification authorization for hospital admittance. Please be sure to contact your insurance company to inform them that you may be admitted. This is the best way to confirm your coverage.
2. This form is designed to make your admission faster and easier. Though you may have sent a copy of your insurance card along with this form, we do need you to bring your insurance card(s) with you when being admitted.
3. Please return this form to:

**Aurora Medical Center**  
 ATTN: Admitting Department  
 1032 E. Sumner Street  
 Hartford, WI 53027  
 T (262) 670-7200  
 F (262) 670-7622

**Aurora Sinai Medical Center**  
 ATTN: Admitting Department  
 945 N. 12Th Street  
 Milwaukee, WI 53233  
 T (414) 219-6054  
 F (414) 219-6735

**Aurora Women's Pavilion**  
 ATTN: Admitting Department  
 8901 W. Lincoln Avenue  
 West Allis, WI 53227  
 T (414) 328-6700  
 F (414) 328-8515