Maternity Pre-Admission Form

Thank you for making the decision to deliver your baby at a Nuvance Health facility. We appreciate the opportunity to share in this special time with you and your family.

Please return the completed Maternity Pre-Admission form and the documents listed below to the appropriate Hospital location. Please do not leave any sections on the form blank. If a section does not apply to you, please write "N/A" in that area.

- Copy of your Insurance Card(s) front and back
- Copy of your Photo ID

Return to: Hospital where scheduled to deliver.

☐**Vassar Brothers Medical Center, Admitting Department, 45 Reade Place, Poughkeepsie, NY 12601**

☐**Northern Dutchess Hospital, Admitting Department, 6511 Springbrook Ave, Rhinebeck, NY 12572**

☐**Putnam Hospital Center, Admitting Department, 670 Stoneleigh Ave, Carmel, NY 10512**

☐ **Sharon Hospital, Admitting Department, 50 Hospital Hill Road, Sharon CT 06069**

Instructions for emailing form: Once is the registration from is completed it must be saved to your computer and sent as an email attachment to: **Maternity.PreRegistrationWest@nuvancehealth.org**

Should you choose to **Fax** your form, please fax it to **the fax number below. If you have any questions, please call the phone number listed below.**

	Fax Number	Phone Number
Vassar Brothers Medical Center	(845)483-6327	(845)483-6273
Northern Dutchess Hospital	(845)871-3619	(845)871-3225
Putnam Hospital Center	(845)278-5538	(845)279-5711 ext. 3088
Sharon Hospital	(860)364-4191	(860) 364-4124

Participating Insurances- please check the Nuvance Health website (www.nuvancehealth.org) to see a list of insurances that each hospital participates with. **Please remember to add your newborn to your insurance policy within 30 days to be covered for this hospital stay.**

Hospital-Based Physicians **and Affiliates**- Although the Hospital of your birthing choice may accept your insurance, some hospital-based physicians and affiliate services may not. We encourage you to check with your insurance company to see if they participate. Please note that hospital-based physicians and affiliates will bill separately from the Hospital of your birthing choice.

We know you have a choice when it comes to healthcare. Thank you for choosing Nuvance Health!

Maternity Pre-Admission Form

Last Name	**First Name**	**Middle Name**	**Maiden Last Name**	**Preferred Name**
Street Address (City, State, Zip Code)				
Mother's Maiden Name	**Home Phone-**Preferred method of Contact? Y or N		**Mobile Phone-** Preferred method of Contact? Y or N	
Religious Preference/House of Worship	**Age**	**Date of Birth**	**Place of Birth**	**Race** / **Ethnicity**
Marital Status: ☐Married ☐ Single ☐ Divorced ☐Widow ☐Legally Separated	**Primary Language**		**Interpreter needed?**	
	Primary Care Physician Name:		**OBGYN or Group Name:**	
Pediatrician or Group Name:	**Delivery Location:** ☐Vassar Brothers Medical Center ☐Northern Dutchess Hospital ☐Putnam Hospital ☐Sharon Hospital			
Date of last menstrual period	**Expected Due date**	**Type of delivery expected.** ☐Normal ☐ Cesarean		
Patient Employer	**Employment status?** ☐Full Time ☐Part Time ☐Unemployed		**Employer Phone**	
Spouse Name	**Spouse Birth Date**	**Spouse Employer**	**Employment status?** ☐Full Time ☐Part Time ☐Unemployed	
Name of PHI Spokesperson/Legal Next of Kin		**Relationship**	**Phone**	
Address (City, State, Zip Code)				
Name of Emergency Contact		**Relationship**	**Phone**	
Do you want to be listed in the patient Directory? This will enable you to receive phone calls, visitors, and flowers. ☐YES ☐ NO		**Do you wish to sign up for the patient portal?** ☐YES ☐ NO **Choose a 4-digit PIN** ____ ____ ____ ____ **What is your email address?**		
MEDICARE: NAME EXACTLY AS ON CARD		**Disability Date**	**Retirement Date**	**ID Number**
MEDICAID: NAME EXACTLY AS ON CARD	**State or County**		**ID Number**	
Name of Primary Insurance Company	**Will Baby be covered under a different insurance than mom?** ☐YES ☐ NO		**Name of Baby's Insurance?**	
Primary Insurance Company Address (Street, PO Box, State, Zip Code)			**Group Plan Name/Employer/or Local Union**	
Phone Number	**Policy ID Number**	**Subscriber Name**		**Subscriber DOB**
Name of Secondary Insurance Company			**Group Plan Name/Employer/or Local Union**	
Secondary Insurance Company Address (Street, PO Box, State, Zip Code)				
Phone Number	**Policy ID Number**	**Subscriber Name**		**Subscriber DOB**