OB PRE-ADMISSION

Ridgeview Medical Center requests that you complete the following pre-admission information. Please mail to Ridgeview Medical Center, Admitting Department, 500 S. Maple Street, Waconia, MN 55387, or Fax to 952-442-6524

All Information Must Be Filled in Below

Today's Date _____ Expected Due Date _____

OB Clinic _____

OB Doctor _____

Family Clinic _____

Family Doctor _____

Baby's Clinic _____

Baby's Doctor _____

Patient Information

Name: (*Last*): _____ (*First*): _____ (*Middle*): _____ (*Maiden*): _____

Mailing Address: (*Street*): _____ (*City*): _____ (*State*): _____ (*Zip*): _____ (*County*): _____

Primary Contact Phone #: _____ E-mail: _____

Marital Status: *(please circle)* S M W Sep D

Birthdate: _____ Age: _____ S.S. # (*needed on birth certificate*): _____

Employer *(Name)*: _____ Work Phone #: _____

Religion *(optional)*: _____ Church *(optional)*: _____

Spouse/Partner Information

Name: (*Last*): _____ (*First*): _____ (*Middle*): _____

Address: _____ Home Phone #: _____

Birthdate: _____ S.S. # (*needed on birth certificate*): _____

Employer *(Name)*: _____ Work Phone #: _____

Nearest Relative

(*Name*): _____ (*Phone*): _____ (*Date of Birth*): _____ (*Relationship*): _____

Other Emergency Contact

(*Name*): _____ (*Phone*): _____ (*Date of Birth*): _____ (*Relationship*): _____

Primary Insurance Company Name: _____ Insurance Ph #: _____

Claims Address: _____

Policyholder: (*Name*): _____ (*Date of Birth*): ____/____/_____ (*S.S. #*): _____

ID/Policy #: _____ Group/Account #: _____

Policyholder's Employer Name: _____ Employer Ph #: _____

Employer Mailing Address: _____

Secondary Insurance Coverage? Yes___ No___

Baby's Primary Insurance Company Name: _____ Insurance Ph #: _____

Claims Address: _____

Policyholder: (*Name*): _____ (*Date of Birth*): _____ (*S.S. #*): _____

ID/Policy #: _____ Group/Account #: _____

Policyholder's Employer Name: _____ Employer Ph #: _____

Employer Mailing Address: _____

Baby Secondary Insurance Coverage? Yes___ No___

If your insurance company requires pre-certification, have you called them? Yes___ No___

Would you like to be contacted with an estimate of charges & benefits? Yes___ No___

Do you have an Advance Directive? Yes___ No___

I acknowledge that Ridgeview Medical Center and Ridgeview Clinics offer a patient portal through FollowMyHealth. Information can be found here - http://www.ridgeviewmedical.org/followmyhealth.

Please check one (1) box:

☐ **I request to be connected to the Ridgeview patient portal. E-mail address to receive a registration link: _____**

☐ **I decline to use Ridgeview's patient portal at this time.**