THE QUEEN'S MEDICAL CENTER

1301 PUNCHBOWL STREET • HONOLULU, HAWAII 96813-2499

Date Completed: _____

OB PRE-REGISTRATION FORM

1) PATIENT INFORMATION

NAME: Last	First	Middle	PHONE: Home

Date of Birth / /	AGE:	SEX: ☐ M ☐ F	SS#: ___ ___ ___ – ___ ___ – ___ ___ ___ ___	PHONE: Work	PHONE: Cell

OB Doctor's Last Name	First Name	EXPECTED DELIVERY DATE ▶

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	Ethnicity:	Queen's Inpatient or Outpatient Before? ☐ YES ☐ NO

Residential Address:	City	State	Zip Code

Billing Address:	City	State	Zip Code

Occupation:	If Military Specify Grade:	VETERAN ☐ YES ☐ NO

Employer:	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ No Employed ☐ Self Employed ☐ AMD
Employer Address: / Phone:	

Nearest Relative or Legal Guardian:			
Relationship:	Phone: Home	Work	Cell

Emergency Contact:	Address	
Relationship:	Phone: Home	Work / Cell

2) PRIMARY Insurance Company

Name:	Policy or ID#:	Group #:
Address:	Plan #:	Cov. Code:
Phone:	Effective Date:	Pediatrician's Name:
Subscriber:	SEX: ☐ M ☐ F / Date of Birth / /	

Relationship to Patient:	Subscriber Address (Residence) (Mailing)	
Employer (Subscriber):	Address	Phone:
Employer (Subscriber): Phone	Occupation:	Employment Status:

3) SECONDARY Insurance Company

Name:	Policy or ID#:	Group #:
Address:	Plan #:	Cov. Code:
Phone:	Effective Date:	Pediatrician's Name:
Subscriber:	SEX: ☐ M ☐ F / Date of Birth / /	

Relationship to Patient:	Subscriber Address (Residence) (Mailing)	
Employer (Subscriber):	Address	Phone:
Employer (Subscriber): Phone	Occupation:	Employment Status:

4) FOR BABY – Insurance Company

Name:	Policy or ID#:	Group #:
Address:	Plan #:	Cov. Code:
Phone:	Effective Date:	Pediatrician's Name:
Subscriber:	SEX: ☐ M ☐ F / Date of Birth / /	

Relationship to Patient:	Subscriber Address (Residence) (Mailing)	
Employer (Subscriber):	Address	Phone:
Employer (Subscriber): Phone	Occupation:	Employment Status: