

CENTRA CARE Health

Sauk Centre

PREREGISTRATION AND BIRTH CERTIFICATE INFORMATION

Please send in this preregistration form to the hospital as soon as possible, but no later than week 28. Put in a stamped envelope and mail to CentraCare Health – Sauk Centre, 425 Elm Street North, Sauk Centre, MN 56378. Thank you!

Estimated date of baby's birth: _____ Baby's last name will be: _____

Do you want a social security number ordered for your baby at birth? Circle: Yes No

MOTHER'S INFORMATION

Mother's legal name: First: _____ Middle: _____ Last: _____

Street address: _____ City: _____ State: _____ ZIP: _____

Mailing address (if different from above): _____ Home phone number: _____

City: _____ State: _____ ZIP: _____

County: _____ In city limits? _____ If out of city, give township: _____

Marital status: Circle: Married Single Separated Divorced Widowed

Maiden name: _____ Birthplace: _____ City: _____ State: _____ Country: _____

Date of birth: _____ Mother's social security number: _____

Race/ethnicity: _____ If Hispanic: Circle: Cuban Mexican Puerto Rican Other Latino

Preferred language: _____ Do you speak English? _____

Education (years): Primary/secondary (K-12): _____ College: _____ Technical: _____

Degree completed? Circle: Associate Bachelor Master Doctorate

Employer: _____ Phone number: _____ Address: _____

Religion: _____ Place of worship: _____

Did you participate in the WIC nutritional program during this pregnancy? Circle: Yes No

If you circled "yes," what month of the pregnancy did WIC begin (1st, 2nd, 3rd, etc.)? _____

Pre-pregnancy weight: _____ First doctor visit for pregnancy (MM/DD): _____ Cigarette use? _____ If yes, number per day: _____

Single mothers: Do you want the birth to be public information at the county courthouse? Circle: Yes No

If you circled "yes," your baby's birth will be listed in the newspaper.

CHILD'S FATHER INFORMATION

Father's name: First: _____ Middle: _____ Last: _____

Mailing address (if different from above): _____ Home phone number: _____

City: _____ State: _____ ZIP: _____

County: _____ In city limits? _____ If out of city, give township: _____

Birthplace: _____ City: _____ State: _____ Country: _____ Date of birth: _____

Father's social security number: _____ Marital status: Circle: Married Single

Race/ethnicity: _____ If Hispanic: Circle: Cuban Mexican Puerto Rican Other Latino

Education (years): Primary/secondary (K-12): _____ College: _____ Technical: _____

Degree completed? Circle: Associate Bachelor Master Doctorate

Employer: _____ Phone number: _____ Address: _____

Religion: _____ Place of worship: _____

PREVIOUS BIRTH INFORMATION

How many children are now living? _____ How many were born alive, but are now deceased? _____

How many miscarriages/stillbirths? _____ Date of last loss? _____

Date of last live birth (prior to this pregnancy): Month: _____ Year: _____

PROVIDER INFORMATION

Your provider/doctor: _____ Primary or family provider/doctor: _____
Baby's provider/doctor: _____

TWO EMERGENCY CONTACTS

Name of contact person: _____ Relationship to patient: _____
Home phone: _____ Cell phone: _____ Work phone: _____

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INSURANCE

Check appropriate space below. Please bring your insurance card with you to the hospital.

Medicare: I.D. number: _____ Coverage: Circle one: A & B A only B only

Blue Cross/Blue Shield: Policy holder's name: _____
I.D. number: _____ Group number: _____

MN Health Care Program/Medical Assistance: Number: _____

Other Insurance:

Name of insurance company: _____
Policy holder's name: _____
Policy number: _____ Group number: _____

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