CENTRACARE Health
Long Prairie

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 – Long Prairie, 20 Ninth Street Southeast, Long Prairie, MN 56347. 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:________________________

Name of contact person:____Relationship to patient:_____________________

Home phone:_________________________________ Cell phone:___________________Work phone:________________________

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
- ❑ B**lue 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:_________________________________
  Name of insurance company:____
  Policy holder's name:____
  Policy number:____________________________________Group number:_________________________________