CentraCare
St. Cloud Hospital

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 Admitting, St. Cloud Hospital, 1406 Sixth Ave. N., St. Cloud, MN 56303. 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:_____