Las Colinas Medical Center OB Pre-Registration Form

6800 N. MacArthur Blvd., Irving, Texas 75039-9711 • 972.969.2101

Send copy of front and back of insurance card along with this completed form and copy of your picture I.D. (driver's license)

Please complete this form and return it to the hospital business office at least five months prior to your due date.

Last Name _____ First Name _____ Middle Initial _____

Age _____ Birth Date _____ Race _____

Address _____ City _____ State _____ Zip _____

Length of Residency _____ Telephone (____) _____ Email: _____

Employer _____ Occupation _____ Length of Employment _____

Employee's Address _____ City _____ State _____ Zip _____

Employee's Telephone (____) _____ Marital Status (circle one) Married Single Widowed Divorced Other

SS# _____ Religion (optional) _____

Physician _____ Due Date _____ Last Menstrual Cycle _____

Previous Admission Yes ____ No ____ Name Used _____ Date _____

Spouse _____ Birth Date _____

Employer _____ Occupation _____ Length of Employment _____

Employer's Address _____ City _____ State _____ Zip _____

Employer's Telephone (____) _____ Spouse's SS# _____

Notify in Emergency _____ Relationship _____ Telephone (____) _____

Address _____ City _____ State _____ Zip _____

GUARANTOR (PERSON RESPONSIBLE FOR BILL)

Last Name _____ First Name _____ Middle Initial _____

SS# _____ Telephone (____) _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Length of Employment _____

Employer's Address _____ City _____ State _____ Zip _____

Employer's Telephone (____) _____

PRIMARY INSURANCE

Insurance Company _____ Telephone (____) _____

Pre-Certification Company _____ Telephone (____) _____

Insured Person _____ SS# _____ Birth Date _____

Employer _____ Telephone (____) _____ Mail to: _____

Group # _____ Policy # _____ Certification # _____ Employer # _____

Union # _____ Plan # _____

SECONDARY INSURANCE

Insurance Company _____ Telephone (____) _____

Pre-Certification Company _____ Telephone (____) _____

Insured Person _____ SS# _____ Birth Date _____

Employer _____ Telephone (____) _____ Mail to: _____

Group # _____ Policy # _____ Certification # _____ Employer # _____

Union # _____ Plan # _____

Please return to Las Colinas Medical Center.