Dear Expectant Parents,

Thank you for making the decision to deliver your baby at the Nuvance Health Family Birth Center. We appreciate the opportunity to share in this special time with you and your family.

In order to help us better serve you, please complete the accompanying, ***Maternity Pre-Admission Form*** in its entirety and mail it to the admitting department within four months of your expected delivery date. Please do not leave any spaces on the form blank. If a section does not apply to you, please write N/A in that area. Should you choose to fax your form please fax it directly to (203) 739-1999.

We have found that there are four areas on the form that generate the most questions. To help you answer these questions, we have provided the following explanations:

Parish/Religion/name on clergy list?
If you would like a visit from clergy while you are in the hospital, answer yes to this question after stating your parish and religion. If you do not want a visit, answer no. Your own clergy is welcomed to visit you in the hospital. By accessing the clergy list on-line, he/she can determine if you've been admitted. In order to insure that we meet your expectations, we will ask if you'd like a visit from our hospital chaplain when you arrive.

Do you have an Advanced Directive?
This is a legal document that the hospital is required to ask for that protects your rights with respect to decisions about your medical care. We've also attached a ***Patient Rights and Organizational Ethics Fact Sheet***, which describes this document in greater detail.

What is a text consent for?
Norwalk Hospital recently launched a text-messaging service to provide you with helpful information throughout your prenatal journey.

We can reach out to you via text to share important reminders and make sure you're aware of the resources we have available for you and your family, such as: Prenatal education classes, Birth tours, Car seat installation, Pediatrician selection, Packing list, Visitor/COVID-19 policies, and Lactation resources

To enroll in the program, we ask for your consent. Please note message & data rates may apply.

Do you want to be listed in the Patient Directory?
In accordance with HIPAA privacy requirements, we must ask if you'd like to be listed in our patient directory. If you answer no to this question, we will not be authorized to tell anyone who calls or visits that you are a patient at Nuvance Health. This includes acknowledgment of flower and/or gift deliveries. The caller or visitor will be told that you are not a patient at Nuvance Health. Please see the attachment entitled, "Patient Directory Opt-out" for additional information.

Having this form completed and on file with the admitting department greatly facilitates the admission process upon your arrival to Labor and Delivery.

We know that you have a choice when it comes to healthcare. Thank you for choosing Nuvance Health!

Instructions for emailing form:
Once the registration form is completed, if emailing the form, it must be saved to your computer and sent as an an email attachment to: Maternity.PreRegistration@nuvancehealth.org

Nuvance Health

Please mail to:
Nuvance Health
Financial Clearance
20 Stony Hill Road
Bethel, CT 06801
Maternity.PreRegistration@nuvancehealth.org

Maternity Pre-admission Form

Patient Name (Last, First MI)	Maiden Name	Patient's Mother's First name	Organ Donor? ☐ Y ☐ N
Street Address (City, State, Zip Code)		Home Phone	Cell Phone
Parish/Religion/ name on clergy list?	Age	Birth date	Place of Birth / Race
Marital Sta ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Legally Separated	Language(Primary)		Delivery Location ◯ Danbury ◯ Norwalk
Doctor's Name	Do you have an Advanced Directive? ☐ Y ☐ N		
Expected Due Date	Text Consent (Norwalk only) ☐ Y ☐ N	Type of Delivery expected? ☐ Normal ☐ Cesarean	Do you smoke? ☐ Y ☐ N
Patient Employer	Patient Occupation		Phone
Employer's Address (City State, Zip Code)			
Spouse/Legal Next of Kin	Relationship	Home Phone	Work Phone
Address (City, State, Zip Code)			
Person to Notify in Emergency	Relationship	Home Phone	Work Phone
Address (City, State, Zip Code)			
Spouse Name		Birth date	Occupation
Spouse Employer			Phone
Do you want to be listed in the Patient Directory ◯ Y ◯ N			
MEDICARE: NAME EXACTLY AS ON CARD		Disability Date / Retirement Date	ID Number
MEDICAID: NAME EXACTLY AS ON CARD		State or Country	ID Number
Name of Primary Insurance Company			
Insurance Company Address (Street, PO Box, City, State, Zip Code)			
Phone Number / Pre-Cert Phone Number		Policy ID Number	Group ID Number
Subscriber Name		Group Plan Name/Employer/or Local Union	
Name of Secondary Insurance Company			
Insurance Company Address (Street, PO Box, City, State, Zip Code)			
Phone Number / Pre-Cert Phone Number		Policy ID Number	Group ID Number
Subscriber Name		Group Plan Name/Employer/or Local Union	

WARNING: CONFIDENTIALITY NOTICE - Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please use caution if deciding to include personal identifying information such as your birth date, or personal medical information in any emails you send to us