



## Maternity Pre-Admission Form

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

Please return the completed Maternity Pre-Admission form and the documents listed below to the appropriate Hospital location. Please do not leave any sections on the form blank. If a section does not apply to you, please write "N/A" in that area.

- Copy of your Insurance Card(s) front and back
- Copy of your Photo ID

**Return to: Hospital where scheduled to deliver.**

- Vassar Brothers Medical Center, Admitting Department, 45 Reade Place, Poughkeepsie, NY 12601
- Northern Dutchess Hospital, Admitting Department, 6511 Springbrook Ave, Rhinebeck, NY 12572
- Putnam Hospital Center, Admitting Department, 670 Stoneleigh Ave, Carmel, NY 10512
- Sharon Hospital, Admitting Department, 50 Hospital Hill Road, Sharon CT 06069

Instructions for emailing form: Once is the registration from is completed it must be saved to your computer and sent as an email attachment to: [Maternity.PreRegistrationWest@nuvancehealth.org](mailto:Maternity.PreRegistrationWest@nuvancehealth.org)

Should you choose to **Fax** your form, please fax it to **the fax number below**. If you have any questions, please call the **phone number listed below**.

	<u>Fax Number</u>	<u>Phone Number</u>
Vassar Brothers Medical Center	(845)483-6327	(845)483-6273
Northern Dutchess Hospital	(845)871-3619	(845)871-3225
Putnam Hospital Center		(845)279-5711 ext. 3088
Sharon Hospital	(860)364-4020	(860) 364-4124

**Participating Insurances-** please check the Nuvance Health website ([www.nuvancehealth.org](http://www.nuvancehealth.org)) to see a list of insurances that each hospital participates with.

**Hospital-Based Physicians and Affiliates-** Although the Hospital of your birthing choice may accept your insurance, some hospital-based physicians and affiliate services may not. We encourage you to check with your insurance company to see if they participate. Please note that hospital-based physicians and affiliates will bill separately from the Hospital of your birthing choice.

**Nuvance Health offers Babyscripts.** A digital education application that provides a daily guide through your pregnancy and postpartum journey. The application provides resources for you and your family; car seat information, lactation services, and what to pack for delivery. To register, scan the QR code. Please Note: The Babyscripts password is NUVANCEBABY.



Android Device



Apple Device

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



# Maternity Pre-Admission Form

Last Name		First Name		Middle Name		Maiden Last Name		Preferred Name	
Street Address (City, State, Zip Code)									
Mother's Maiden Name				Home Phone-Preferred method of Contact? Y or N			Mobile Phone- Preferred method of Contact? Y or N		
Religious Preference/House of Worship			Age	Date of Birth		Place of Birth		Race	Ethnicity
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Legally Separated				Primary Language			Interpreter needed?		
				Primary Care Physician Name:			OBGYN or Group Name:		
Pediatrician or Group Name:				Delivery Location: <input type="checkbox"/> Danbury Hospital <input type="checkbox"/> Norwalk Hospital			<input type="checkbox"/> Vassar Brothers Medical Center <input type="checkbox"/> Putnam Hospital <input type="checkbox"/> Northern Dutchess Hospital		
Date of last menstrual period		Expected Due date			Type of delivery expected. <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean				
Patient Employer				Employment status? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed			Employer Phone		
Spouse Name			Spouse Birth Date		Spouse Employer		Employment status? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed		
Name of PHI Spokesperson/Legal Next of Kin					Relationship		Phone		
Address (City, State, Zip Code)									
Name of Emergency Contact					Relationship		Phone		
Do you want to be listed in the patient Directory? This will enable you to receive phone calls, visitors, and flowers. <input type="checkbox"/> YES <input type="checkbox"/> NO					Do you wish to sign up for the patient portal? <input type="checkbox"/> YES <input type="checkbox"/> NO Choose a 4-digit PIN _____ What is your email address?				
MEDICARE: NAME EXACTLY AS ON CARD					Disability Date		Retirement Date		ID Number
MEDICAID: NAME EXACTLY AS ON CARD				State or County			ID Number		
Name of Primary Insurance Company				Will Baby be covered under a different insurance than mom? <input type="checkbox"/> YES <input type="checkbox"/> NO			Name of Baby's Insurance?		
Primary Insurance Company Address (Street, PO Box, State, Zip Code)									
Phone Number		Policy ID Number			Subscriber Name		Group Plan Name/Employer/or Local Union		
Name of Secondary Insurance Company									
Secondary Insurance Company Address (Street, PO Box, State, Zip Code)									
Phone Number		Policy ID Number			Subscriber Name		Group Plan Name/Employer/or Local Union		