



Mail to:
St. Anthony's Memorial Hospital
Attention: Registration Department
503 N Maple
Effingham, IL 62401

Patient Label
Hospital Use Only

Labor Pre-Admission Form

Demographic Information for Mother:

Complete approx. 6 weeks before
your due date and mail or take to
the hospital for pre-registration.

Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Maiden/Other Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ Phone (O): _____ Marital Status: _____

SSN: _____ Race: _____ Religion/Affiliation: _____

Ethnicity: Hispanic/Non-Hispanic Birth St.: ___ Do you want to be a confidential patient? Yes/No

Emp. Status: Full Time/Part Time/Self-Employed/Student/Unemployed/Retired/Active Military

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Next of Kin: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone(s): _____

Relationship to Patient: _____

Person to Notify: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone(s): _____

Relationship to Patient: _____



Mail to:
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Mother's Label
Hospital Use Only

Newborn Pre-Admission Form

If any of the following information differs from the Mothers, please indicate the changes below.

Newborn Demographic Information:

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Religion: _____ Race: _____

Is Next of Kin the Mother? Yes/No _____ Newborn's Physician: _____

Billing and Insurance Information for Newborn:

Guarantor: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Rel to Pt: _____

Birth date: _____ SSN: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emp. Status: Full Time/Part Time/Self-Employed/Student/Unemployed/Retired/Active Military

Insurance: _____

Policy/ID #: _____

Subscriber/Policy Holder: _____

Address: _____

City, State , Zip: _____

Phone: _____ Birth Date: _____ Sex: _____

Social Security Number: _____ Relationship to Patient: _____

Effective Date: _____ Group Name: _____ Group Number: _____

Employer: _____ Employment Status: _____

Pre-Cert Phone #: _____



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Billing and Insurance Information for Mother:

Guarantor: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Rel to Pt: _____

Birth Date: _____ SSN: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emp. Status: Full Time/Part Time/Self-Employed/Student/Unemployed/Retired/Active Military

Insurance: _____

Policy/ID #: _____

Subscriber/Policy Holder: _____

Address: _____

City, State, Zip: _____

Phone: _____ Birth Date: _____ Sex: _____

Social Security Number: _____ Relationship to Patient: _____

Effective Date: _____ Group Name: _____ Group Number: _____

Employer: _____ Employment Status: _____

Pre-Cert Phone #: _____

Other Information for Mother:

Physician: _____ Due Date: _____