# maternity pre-registration information

**Patient Information** (Mandatory) (PLEASE PRINT)

First Name | Middle | Last

Address | City | State | Zip

Date of Birth

**Sex at Birth** ☐ Male ☐ Female

**Preferred Gender** ☐ Male ☐ Female ☐ Female-to-male (FTM) / Transgender Male / Trans Man ☐ Male-to-female (MTF) / Transgender Female / Trans Female ☐ Genderqueer, neither exclusively male nor female ☐ Decline to answer

**Preferred Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Hawaiian or Other Pacific Islander ☐ White

**Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

**Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widow

Preferred Language | OBGYN Name

Social Security Number | Primary Care Physician

Work Phone | Cell Phone

Employer

Email | Religious Preference

Expected Due Date | Last Menstrual Period

Is it okay to list on our public hospital directory? ☐ Yes ☐ No

**Responsible Person** (Please complete if under age 18.)

Name | Date of Birth

Address | City | State | Zip

Gender ☐ Male ☐ Female | Social Security Number

Work Phone | Cell/Home Phone

Employer

FLOYD Medical Center

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## Emergency Contact

Name | Relationship to Patient

Phone

## Second Emergency Contact (not living at home)

Name | Relationship to Patient

Phone

## Insurance Information

### Primary Insurance

Insurance Company Name | Subscriber Name

Date of Birth of policy holder

Member ID # | Group #

### Second Insurance

Insurance Company Name | Subscriber Name

Date of Birth of policy holder

Member ID # | Group #

**For all patients, a copy of your legal photo I.D. is required.**

**For all insured patients, a copy of your current insurance card (front and back) is required.**

*I certify that the above information is correct and accurate to the best of my knowledge.*

Patient Signature | Date

Patient Representative Signature | Date

**After your forms are completed, one of our team members will contact you for next steps ...**

You may mail, fax or return this form in person with a copy of both sides of your health coverage card. For more information, call us at 706.509.5980.

**Mail:**
Floyd Medical Center
Main Admissions / Registration
PO Box 233
Rome, GA 30162 - 0233

**Fax:**
706.509.5991

In Person:
Visit the Guest Relations desk in the Floyd Medical Center main entrance lobby Monday through Friday between the hours of 8 a.m. and 6 p.m.

FLOYD Medical Center