



COLUMBIA CENTER

The little things make us special

Welcome to Columbia Center. We look forward to the opportunity to care for you and your new baby. Please complete this pre-admission form and return it as soon as possible so we may join you in your journey of childbirth planning and parenting.

Please return the completed form to: Columbia Health System, Inc., 13125 N Port Washington Rd Mequon, WI 53097, Phone: 262-243-7408, Fax: 262-243-6672.

Please visit us online at www.columbiacenter.org

MATERNITY INFORMATION

Form with sections for EXPECTANT MOTHER and SPOUSE, containing fields for Due Date, Physician, Baby's Physician, Last Name, First Name, MI, Previous Name, Social Security Number, Birth Date, Martial Status, Race, Address, City, State, Zip, Home Phone, Work Phone, Cell Phone, Email Address, Religion, Occupation, Primary Language, Employer Name, and Employer Address.

EMERGENCY NOTIFICATION

Emergency notification form with fields for Name, Address, City, State, Zip, Home Phone, Work Phone, Relationship to Patient, and Birth Date.

Please turn over and complete the other side of this form.

INSURANCE PLAN ONE

Insurance Company Name		Policy or ID Number		Group Number	
Policyholder Name	Phone (Benefits) ()	Phone (Precertification) ()	Employer Name		

INSURANCE PLAN TWO

Insurance Company Name		Policy or ID Number		Group Number	
Policyholder Name	Phone (Benefits) ()	Phone (Precertification) ()	Employer Name		

PRIVACY

1) Would you like to be included in our facility directory so that your visitors, phone calls and deliveries may be directed to you?
 Yes No

Without being in the directory, we will not be able to forward any phone calls or visitors to you including family members.

2) Would you like for us to share relevant health information with your family or others who are involved in your care?
 Yes No I have restrictions

If you have checked that you have restrictions, please discuss these restrictions with your care provider.

ADVANCED DIRECTIVES

Do you have a living will?
 Yes No

If yes, please attach a copy to place in your chart.
 If no, would you like information on living wills? Yes No

Do you have a durable power of attorney for health care (DPOA)?
 Yes No

If yes, please list the name and the phone # of your DPOA:
 Name: _____ Phone: ()

If no, would you like information on durable power of attorney? Yes No

HOW DID YOU HEAR ABOUT US?

Please check one of the following:

From a friend or relative I received a direct mailing at my home address
 From my doctor Ad in magazine or newspaper
 Columbia Center website Other:

FOR OFFICE USE ONLY

Issue Date	MD	ZC	EDC
------------	----	----	-----