



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 guide you in your journey of childbirth planning and parenting.

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

Please visit us online at columbiacenter.org

EXPECTANT MOTHER INFORMATION

Due Date / /	Physician or Midwife	Baby's Physician	Date of Last Menstrual Period / /	
Last Name	First Name	MI	Previous Name	
Social Security Number - -	Birth Date / /	Marital Status		Race
Address		City	State	Zip
Home Phone ()	Cell Phone ()		Work Phone ()	
Email Address		Religion	Occupation	Primary Language
We will use your email address to send you information about childbirth resources and events at Columbia Center, including our email newsletter, <i>Mom e-news</i> . The newsletter offers tips on a variety of topics on pregnancy, birth and beyond. We may use your email to communicate important information about classes you may be attending. Columbia Center will never share or sell your information. <input type="checkbox"/> Please do not send me <i>Mom e-news</i> .				
Employer Name		Employer Address, City, State, Zip		

SPOUSE/OTHER INFORMATION

Last Name	First Name	MI	Birth Date / /	
Address		City	State	Zip
Social Security Number - -	Home Phone ()	Cell Phone ()	Work Phone ()	
Occupation	Employer Name	Employer Address, City, State, Zip		

EMERGENCY CONTACT INFORMATION

<input type="checkbox"/> Use Spouse/Other Information. Complete this section only if different from spouse/other information.				
Name		Address, City, State, Zip		
Home Phone ()	Cell Phone ()	Work Phone ()	Relationship to Patient	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	

ADVANCED DIRECTIVES

Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please attach a copy to place in your chart. If no, would you like information on living wills? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a durable power of attorney for health care (DPOA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list the name and phone number of your DPOA: Name: _____ Phone: () _____ If no, would you like information on durable power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	

HOW DID YOU HEAR ABOUT YOUR PHYSICIAN?

Please check one of the following:	
<input type="checkbox"/> Friend or relative	<input type="checkbox"/> Insurance provider
<input type="checkbox"/> Columbia Center website	<input type="checkbox"/> Internet
<input type="checkbox"/> Direct mailing at my home address	<input type="checkbox"/> Other:

HOW DID YOU HEAR ABOUT COLUMBIA CENTER?

Please check one of the following:	
<input type="checkbox"/> Friend or relative	<input type="checkbox"/> milwaukeeemoms.com
<input type="checkbox"/> Physician	<input type="checkbox"/> Movie Theater
<input type="checkbox"/> Columbia Center website	<input type="checkbox"/> Ad on a bus
<input type="checkbox"/> Billboard	<input type="checkbox"/> Radio
<input type="checkbox"/> Facebook	<input type="checkbox"/> Newspaper/magazine
<input type="checkbox"/> Bayshore Mall	<input type="checkbox"/> Other:
<input type="checkbox"/> Direct mailing at my home	



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