

**OB PRE-ADMIT PACKET**

Thank you for choosing Blount Memorial Hospital for the birth of your new child.

**Due Date:** \_\_\_\_\_ **OB Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

Vaginal

C-Section

Tubal

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Alt #: \_\_\_\_\_

**Would you like to participate in the Patient Portal – secure access to your Health Information at any time.**

**If so, Please provide us your E-mail address:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Work # and Ext:** \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_

**Phone/Cell #:** \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Work # and Ext:** \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

**(continue on back)**

**Emergency Contact Other than Spouse:** \_\_\_\_\_

Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Insurance Information:**

**Primary Insurance:** \_\_\_\_\_

Phone # On Card: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Phone # On Card: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

**What insurance do we need to bill for your newborn:** \_\_\_\_\_

- **To insure coverage for your child, your Human Resource Department/ Insurance Company has to be notified after you have given birth to your child.**

Please Pre- Admit at least 30 days prior to delivery. The packet may be dropped off at the Outpatient Registration office located on the first floor of the hospital Monday- Friday 6am until 6pm. Or you may mail the packet to:

Admissions Department  
Blount Memorial Hospital  
907 E. Lamar Alexander Pkwy.  
Maryville, Tenn. 37804

**Please provide a copy of your insurance card. You will be receiving a call from a Financial Counselor regarding your benefits. All co-pays and deductibles will need to be paid prior to delivery. Any change in information provided will need to be called to the Admitting to update your information: 865-980-4882.**