



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:

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 State: _____ Do you want to be a confidential patient? Yes / No

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

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: _____



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Billing and Insurance Information for Mother:

Guarantor: _____ Address: _____

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

Birthdate: _____ SSN: _____

Employer: _____ Address: _____

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

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

Insurance: _____

Policy/ID #: _____

Subscriber/Policy Holder: _____

Address: _____

City,State,Zip: _____

Phone: _____ Birthdate: _____ 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: _____



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 change below.

Newborn Demographic Information:

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

Phone: _____ Religion: _____ Race: _____ Ethnicity: _____

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

When the baby is born would you like it to be a confidential patient? Yes/No

Guarantor: _____ Address: _____

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

Birthdate: _____ SSN: _____

Employer: _____ Address: _____

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

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

Insurance: _____

Policy/ID #: _____

Subscriber/Policy Holder: _____

Address: _____

City,State,Zip: _____

Phone: _____ Birthdate: _____ Sex: _____

Social Security Number: _____ Relationship To Patient: _____

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

Employer: _____ Employment Status: _____

Pre-Cert Phone #: _____