Pre-Registration with Baylor University Medical Center

We advise you to pre-register to the hospital for your delivery. This will expedite the care in which you receive.

There are 3 different methods in which you can use to register:

1. Online:
   a. Go to: www.baylorhealth.com/dallaschildbirth.
   b. Look for the link to "Pre-Register for Your Delivery".
   c. Select the hospital in which you will be delivering: Baylor University Medical Center at Dallas.
   d. Complete the form in its entirety and press "submit" (please verify that you have the correct hospital selected).
2. In person:
   a. Complete the "Maternity Pre-admission Information" sheet.
   b. Bring completed form to Baylor University Medical Center at 3500 Gaston Avenue, 1st floor of the Jonsson Hospital, Patient Registration.
   c. Please have your driver's license and insurance card with you.
3. Mail:
   a. Complete the "Maternity Pre-Admission Information" sheet.
   b. Make a copy of your driver's license and insurance card.
   c. Mail all three items (Pre-admission form, copy of driver's license, and copy of insurance card) to: Jonsson Admitting
      Baylor University Medical Center
      3500 Gaston Avenue
      Dallas, Texas 75246

BAYLOR UNIVERSITY MEDICAL CENTER

3500 Gaston • Dallas, Texas 75246

MATERNITY PRE-ADMISSION INFORMATION–PLEASE PRINT

Your Doctor _____ Due Date _____

Dr. Add./Phone # _____

Your Pediatrician _____

Is C-Section Anticipated? _____

PATIENT

Legal Last Name	Full First Name	Full Middle Name	Maiden Name

Marital Status ☐M ☐W ☐S ☐D	Age	Date of Birth	Social Security Number	Home Phone Number Area Code ( )

Street Address	City	State	Zip Code	County	Is Residence Inside City Limits?

Name of Employer	Occupation	Length of Employment	Phone Number Area Code ( )

Employer Address	City	State	Zip Code

What kind of Business or Industry is Employer?

Previous Admission at Baylor? ☐ Yes ☐ No Date:

Under what name?

Religious Preference/Church Name

BELOW: HUSBAND (INFORMATION NEEDED FOR BIRTH CERTIFICATE)

GUARANTOR (Person Responsible for Hospital Charges)

Last Name	Full First Name	Full Middle Name	Relation to Patient

Street Address	City	State	Zip Code	Home Phone Number Area Code ( )

Name of Employer	Occupation	Length of Employment	S.S. #

Employer Address	City	State	Zip Code	Phone Number

What kind of Business or Industry is Employer?

EMERGENCY NOTIFICATION (Other than Above)

Relative or Friend's Name	Relation to Patient	Home Phone No. (and Area Code)

Street Address	City	State	Work Phone No. (and Area Code)

Information required by the STATE OF TEXAS for proper registration of your baby's birth.

Not including this birth	(A) How many other children are now living?

(B) How many other children were born alive but are now dead?	(C) How many children were born dead after 20 weeks pregnancy?

Patient's Birthplace (state or county)	Race	Is patient of Spanish origin?	If yes, specify Mexican, Puerto Rican, Cuban, etc.

Husband's Birthplace (state or county)	Race	Is patient of Spanish origin?	If yes, specify Mexican, Puerto Rican, Cuban, etc.

Husband's Age	Husband's Date of Birth

Please See Other Side

PATIENT INSURANCE COVERAGE

As a hospital service, Baylor University Medical Center will file up on to three insurances for you. Please supply full information on insurances that you would like to list with the hospital and be prepared to show your insurance I.D. cards at the time of your admission. Thank You.

MEDICAID RECIPIENT # _____

INSURANCE #1

Insurance Company Name	Phone #	Type: ❑ Group (Through Employer/Association) ❑ Individual (Through Individual Insurance Agent)	
Insurance Street Address:	City:	State:	Zip Code:
Name of Person Insured (Policyholder)			Relation to Patient
Name of Employer/Association (if group insurance)			Employer Phone # (& Area Code)
Employer Address:	City:	State:	Zip Code:
Policy I.D., or Certificate Number:	Group or Code Number:	Is Precertification Required?	

Have you called to precertify the admission?_____ Pre-authorization # _____ Pre-authorization Phone # _____

INSURANCE #2

Insurance Company Name	Phone #	Type: ❑ Group (Through Employer/Association) ❑ Individual (Through Individual Insurance Agent)	
Insurance Street Address:	City:	State:	Zip Code:
Name of Person Insured (Policyholder)			Relation to Patient
Name of Employer/Association (if group insurance)			Employer Phone # (& Area Code)
Employer Address:	City:	State:	Zip Code:
Policy I.D., or Certificate Number:	Group or Code Number:	Is Precertification Required?	

Have you called to precertify the admission?_____ Pre-authorization # _____ Pre-authorization Phone # _____

INSURANCE #3

Insurance Company Name	Phone #	Type: ❑ Group (Through Employer/Association) ❑ Individual (Through Individual Insurance Agent)	
Insurance Street Address:	City:	State:	Zip Code:
Name of Person Insured (Policyholder)			Relation to Patient
Name of Employer/Association (if group insurance)			Employer Phone # (& Area Code)
Employer Address:	City:	State:	Zip Code:
Policy I.D., or Certificate Number:	Group or Code Number:	Is Precertification Required?	

Have you called to precertify the admission?_____ Pre-authorization # _____ Pre-authorization Phone # _____

LIVING WILL

1. Do you have a Living Will? (circle one) yes no If yes, where is it located? _____
2. In the event that you are unable to make medical decisions for yourself, have you named someone to make these decisions? yes no
   If yes, who is that person? _____
3. If you have a durable power of attorney for health care, where is it located? _____

TO BE FILLED OUT BY THE RN ONLY: Information on advance directives given to patient _____