Hartford HealthCare
St. Vincent's Medical Center

Thank you for choosing The Family Birthing Center at St. Vincent's Medical Center for your birthing needs. We look forward to making this a wonderful experience for you, your family, and your new baby!

By completing the pre-admission form and sending it back to us, you are providing us with the initial information we need to get ready for your hospital stay. Please mail it back using the self-addressed envelope or fax the completed form to (475) 210-5738.

Please be sure to bring your driver's license (or other forms of identification) and insurance card to the hospital at the time of admission.

As you arrive to the Main Entrance of Saint Vincent's Medical Center, your spouse or birthing partner may park in the visitors parking lot directly across from the main entrance. Upon entering the main entrance to the hospital, you and your support person should go to the security desk. A hospital employee will bring you and your support person to the elevators and direct you to level 5.

Between the hours of 8pm-6am, please enter the hospital through the Emergency Room entrance.

You and your support person will arrive on level 5, where a member of the team will complete the arrival process. The nurse will assess you, begin the admission process, and talk with your doctor.

For more information regarding your upcoming delivery, please visit our website at https://stvincents.org/services/maternity or call the unit at (475) 210-6080.

Financial Arrangements

Hospital insurance plans frequently do not provide full coverage of your hospital bill. With the exception of Medicare and Medicaid, your hospitalization coverage is a contract between you and your insurance company. While we will cooperate to the fullest in expediting your claim, you are ultimately responsible for payment of your account in full.

Your plan may have special requirements, such as a second surgical opinion or pre-certification for certain tests or procedures. It is your responsibility to make sure the requirements of your plan have been met. If your plan's requirements are not followed, you may be financially responsible for all or part of the services rendered in the Medical Center. Some physician specialists may not participate in your health-care plan, and their services may not be covered.

Hartford HealthCare (HHC) provides financial assistance to all eligible individuals who meet the criteria in our Financial Assistance Policy. It is HHC's policy to provide, without discrimination, emergent care for everyone regardless of their eligibility for medical benefits, financial or government assistance. Your questions about the Financial Assistance Policy and the Application for Financial Assistance, the terms and eligibility can be requested in person through any HHC employee, via telephone 1-888-515-5544 or on our website, www.HartfordHealthCare.org

Maternity Pre-Admission Form

Please mail or fax this form to (475) 210-5738

Revised 11-9-2020

Expected Due Date	**Date of Last Menstrual Period**	**Delivering Physician (ObGyn Doctor)**

Patient Last Name	**Patient First Name**	Social Security #	DOB

Street Address	City	State	Zip Code

Phone #: Home: _____ Mobile: _____ Work:_____	**Interpreter Needed**: ☐Yes ☐ No Language spoken: _____ Language Written: _____	**Race** ☐White ☐Black ☐Asian ☐ American Indian ☐ Pac Islander/Haw ☐ Patient Refused ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Refused ☐ Unknown	Marital Status ☐Single ☐ Married ☐ Widowed ☐Divorced ☐ Legal Separated ☐Unknown ☐ Significant Other Maiden Name: _____	**Religion** _____ **Place of Worship** _____	Are you a Veteran? ☐Yes ☐ No

E-Mail Address	**Primary Care Physician Name**

In the Event you are admitted to the hospital, do you want your Primary Care Physician Notified?
☐ YES ☐ NO ☐ NO- I do not have a PCP

Employer Name Occupation

Employment Status
☐Full Time ☐ Part Time ☐Full Time Student ☐ Part Time Student ☐Retired ☐Disabled☐ Active Military Duty☐ Not Employed

Emergency Contact - Name	Street Address, City & Zip Code	Relationship to Patient
Contact Home Phone( )	Contact Work Phone ( )	Contact Mobile Phone ( )

Name of Person Financially Responsible For Bill/Guarantor	☐ Female ☐ Male	Guarantor Tel # ( )	Pt. Relationship to Guarantor ☐Self ☐ Spouse ☐ Other_____
Guarantor Address	Guarantor employer		

Employment Status
☐Full Time ☐ Part Time ☐Full Time Student ☐ Part Time Student ☐Retired ☐Disabled☐ Active Military Duty☐ Not Employed

Primary Insurance Company	**Policy Number**

Subscriber's Name	Date of Birth	Social Security #	☐ Female ☐ Male

Subscriber's Employer	Employment Status ☐Full Time ☐ Part Time ☐ Unknown ☐Full Time Student ☐ Part Time Student ☐Retired ☐Disabled☐ Active Military Duty☐ Not Employed

Secondary Insurance Company	**Policy Number**

Subscriber's Name	Date of Birth	Social Security #	☐ Female ☐ Male

Subscriber's Employer	Employment Status ☐Full Time ☐ Part Time ☐ Unknown ☐Full Time Student ☐ Part Time Student ☐Retired ☐Disabled☐ Active Military Duty☐ Not Employed

Would you like your stay to be **private**? If answered "Yes", no visitors or deliveries (flowers, cards etc..) will be allowed.
☐Yes ☐ No

In the event you are admitted to the hospital, for privacy, most patients contact their own family and/or friends. Do you need the hospital to contact anyone on your behalf?
☐ No ☐ Yes If YES, enter Emergency Contact name & Phone to be Contacted:
Contact name: Contact Phone#

****Office Use Only****

Unit: SVMC Family Birth Center **Patient Class**: Outpatient **Service**: Obstetrics **Diagnosis:** Pregnancy
Point of Origin ☒ Non Healthcare Facility **Admission Type**: ☒Elective **Occurrence Code**: ☒10 – Last Menstrual Period