OBSTETRICAL PRE-ADMISSION FORM

Baton Rouge General

Please complete and return immediately to:
Baton Rouge General Medical Center – Bluebonnet
Attn: Admitting, 8585 Picardy Avenue, Baton Rouge, LA 70809

PERSONAL INFORMATION:

Name: _____ _____ _____
First *Middle Initial* *Last*

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Phone#: (___) _____ Due Date: _____

Date of Birth: *Month*_____ *Day*_____ *Year* _____ Race: _____

Religion: _____ Church: _____

Obstetrician: _____ Pediatrician: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated

Employer: _____ Address: _____

Phone#: (___) _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT/NOT LIVING WITH PATIENT:

Name: _____ Relation: _____

Phone#: (____) _____ Alternative Phone#: (___) _____

INSURANCE INFORMATION:

Primary Insurance: _____ Subscriber: _____

Insurance Phone#: (____) _____ Employer: _____

Group#: _____ Policy #: _____

Secondary Insurance: _____ Subscriber: _____

Insurance Phone#: (____) _____ Employer: _____

Group#: _____ Policy #: _____

Will newborn be added to above insurance? ❑ Yes ❑ No If ***No***, please list insurance carrier information for newborn:

Primary Insurance: _____ Subscriber: _____

Insurance Phone#: (____) _____ Employer: _____

Group#: _____ Policy #: _____

LIVING WILL: ❑ Yes ❑ No Info: ❑ Yes ❑ No