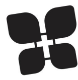

AdventHealth
Shawnee Mission

Pre-Admission Form

PATIENT INFORMATION				If you have any questions, please call 913-632-4233.
Last Name:	First Name:	MI:	Previous Last Name: ❑ N/A	
DOB:	SSN:	Marital Status: ❑ Married ❑ Separated ❑ Single ❑Life Partner ❑Divorced		
Address:	City:	State:	Zip:	
Contact Preference: ❑ Home ❑ Mobile	Permission to Text or Voicemail: ❑Yes ❑ No			
Primary Phone:	Alternate Phone:	Email:		
Preferred Language:	Religious Preference:	Race:		
OB/GYN:	Primary MD:	Estimated Due Date:	Last Menstrual Date:	
Employment Status: ❑ Full Time ❑ Part Time ❑ Self-employed ❑ Not employed ❑Student				
Employer Name:	Employer Address:	Employer Phone:		

EMERGENCY CONTACTS			
Primary Contact Name:		Patient Relationship to Contact:	
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Secondary Contact Name:		Patient Relationship to Contact:	
Home Phone:	Work Phone:	Cell Phone:	

MOTHER'S INSURANCE INFORMATION		**Copies of your insurance cards must be attached.**	
Insurance 1: Company Name:	**Policy #**	**Group #**	
Subscriber Name:	Relationship to Subscriber		
Subscriber Address:	City:	State:	Zip:
Subscriber Date of Birth:	Subscriber SSN:		
Subscriber Employer:	Subscriber Employer Phone Number:		
Insurance 2: Company Name:	**Policy #**	**Group #**	
Subscriber Name:	Relationship to Subscriber:		
Subscriber Address:	City:	State:	Zip:
Subscriber Date of Birth:	Subscriber SSN:		
Subscriber Employer:	Subscriber Employer Phone:		

BABY'S INSURANCE INFORMATION		***Anticipated insurance plan after the birth of your baby.***	
Insurance 1: Company Name	**Policy #**	**Group #**	
Subscriber Name:	Baby's Relationship to Subscriber:		
Subscriber Address:	City:	State:	Zip:
Subscriber Date of Birth:	Subscriber SSN:		
Subscriber Employer:	Subscriber Employer Phone:		
Insurance 2: Company Name	**Policy #**	**Group #**	
Subscriber Name:	Baby's Relationship to Subscriber		
Subscriber Address:	City:	State:	Zip:
Subscriber Date of Birth:	Subscriber SSN:		
Subscriber Employer:	Subscriber Employer Phone Number:		

PLEASE BE ADVISED THAT PATIENT FINANCIAL RESPONSIBILITY WILL BE EXPECTED AT TIME OF SERVICE.
For billing or self-pay questions, please call the Maternity Financial Specialist at 913-632-4104.

Your Next Steps

- Begin your journey with us at 20 weeks of pregnancy by mailing in this form, including copies of all insurance cards. **I have included copies of:**
  - ❑ Front of insurance cards
  - ❑ Back of insurance cards
- At 30 weeks, call to schedule an appointment with one of our Maternity Navigators at 913-632-4233.