PINNACLEHEALTH
Hospitals

Patient Registration Department
Harrisburg Hospital
P.O. Box 8700
Harrisburg, PA 17105-8700

Dear Patient:

When you're in labor, the last thing you want to do is fill out paperwork and answer routine questions. That's why we suggest that expectant mothers **pre-register with Harrisburg Hospital after their first prenatal appointment:**

- **Please complete the attached form and return it to the hospital as soon as possible.** This information is very important, and we should have it prior to your admission. It can be mailed to the above address or faxed to (717) 782-5489.
- If you have questions while completing this form, you may call the Patient Registration Department, Harrisburg Hospital at (717) 782-5213 and we will gladly assist you.
- In your last trimester we will send you a packet of information, which will be helpful for planning your stay with us.
- At your convenience, you may stop at Patient Registration to have your insurance cards copied. Patient Registration is located on the first floor of the hospital on the Harrisburg Campus.
- If you are unable to stop by Patient Registration ahead of time, please be sure to bring your insurance cards with you when you are admitted so we may verify the information at that time.
- Should there be a change in your insurance after you send in your form, please call the above number so we can update your information.
- When arriving for admission after 8 p.m. please use the Emergency Department Entrance. Staff there will be available to assist you, if needed.
- Please make a copy of this cover letter in case you have any future changes or questions that you would like to address with Patient Registration.

Thank you for choosing PinnacleHealth. We look forward to caring for you and your baby.

PLEASE COMPLETE THIS MATERNITY PREREGISTRATION FORM AND MAIL IMMEDIATELY

Print or type all information

Expected delivery date	Admitting Physician (list one only, please)

Patient Name - Last	First	MI	Maiden Name	Marital Status	Race

Address	City	State	ZIP Code plus 4

Home Phone	Other Phone	Birthdate	Social Security #	Religious Preference
( )	( )			

E-Mail Address

Occupation	Employer	Address	Employer Phone #
			( )

Spouse/Emergency Contact Name	Address	Home Phone #	Work Phone #
		( )	( )

Additional Contact Person Name	Address	Home Phone #	Work Phone #
		( )	( )

Name of Family Doctor/Primary Care Physician		Phys. Phone #

Please list all insurance coverage:					Relation to Patient
Subscriber Name	Social Security #	Policy #	Group #	Subscriber Birthdate	

Insurance Company Name and Address	Precert Required?	Insurance Co. Phone #
	Yes___ No___	( )

Employer Name and Address	Employer Phone #
	( )

Subscriber Name	Social Security #	Policy #	Group #	Subscriber Birthdate	Relation to Patient

Insurance Company Name and Address	Precert Required?	Insurance Co. Phone #
	Yes___ No___	( )

Employer Name and Address	Employer Phone #
	( )

Medical Assistance/Medicaid HMO REC/ID#		

Fax to: (717) 782-5489 or Mail to: Patient Registration Department, Harrisburg Hospital, PO Box 8700, Harrisburg, PA 17105-8700