

Obstetrical Pre-Registration Form



Last Name		First Name		Middle Name		Prior Surname(s)/Maiden Name	
Address			Apt. #	Religion		Mother's First Name	
City, Town, Village			Family Doctor			Employer	
Postal Code		Province		Medical Alerts/Allergies/Food Allergy			
Home Phone Number							
Age		Date of Birth (Y/M/D)		Business Phone Number		Ext.	
Name of Primary Contact in Case of Emergency					Relationship to Patient		
Address Same as above, or			Home Phone Number		Business Phone Number		Ext.
Expected Date of Birth (D/M/Y)		E-mail Address		Please state which pregnancy this is:		Doctor/Midwife	
Health Insurance Information							
Is this patient covered under Ontario Health Insurance Plan? Yes No				Health Insurance Number		Version Code	
Last Name on Health Card:							
Do you have supplementary Insurance for semi or private coverage? Yes No							
PLEASE COMPLETE if you have supplementary Insurance for all Day Surgery, Inpatient and Outpatient procedures.							
If yes, name of Insurance Company				Policy, Group or Contract #			
Certificate in name of Patient Other				Certificate or I.D. #			
Name of Policy Holder				Employer's Name			
Relationship to Patient				Employer's Address			
Insurance Coverage provided by employer Yes No				Employer's Telephone Number			
Out of Province / Out of Country Information				Preferred Accommodation			
Address of province of origin:				Semi-private Private Ward			
Home Phone Number				Basic Ward Coverage			
Business Phone Number				<ul style="list-style-type: none"> • Ontario Resident without Ontario Health Insurance, Landed Immigrant Status \$1432.00/day • Resident of another Province in Canada with valid provincial Health Card (This is billed to Provincial Insurance) \$1187.00/day • Non-Resident of Canada \$3150.00/day • Refugee Status, F.A.S. \$636.83/day 			
Cell Phone Number				Preferred Accommodation			
Credit Card Information: If OHIP or private insurance does not cover the full cost of your stay, your credit card will be billed.				Please check your Accommodation request and provide insurance information if applicable.			
Payment Information: Mastercard Visa American Express				Ontario Residents Non Residents of Ontario			
Name of Card Holder (please print)				<ul style="list-style-type: none"> • Standard Ward \$0.00 \$3150.00/day • Semi-Private (2 beds to a room) \$215.00/day • Private (1 bed in the room) \$250.00 			
Credit Card Number		Security Code		Expiry Date			
Signature							
06:30 am to 21:00 - OB 4th floor 21:00pm to 06:30am - ER Triage				Do not bring any valuables. The hospital assumes NO responsibility for lost or stolen items.			
NOTE: It is important that all above information is complete in its entirety prior to coming to Cambridge Memorial Hospital.							
Please fax the form from your Doctor's Office or Midwife's Office to 519-740-4944.							