



# North Memorial Medical Center

3300 OAKDALE AVENUE NO.  
ROBBINSDALE, MN 55422-9988

## Pre-Admission Forms

**Thank you for choosing North Memorial Medical Center for the birth of your baby!**

Before you have your baby, we would like you to take a moment to fill out the attached forms included in this package. Completing these forms prior to your stay at North Memorial will allow for a smoother registration and more satisfying birth experience.

**Complete the following forms and bring them with you to North Memorial when you deliver your baby:**

**Birth Certificate Information** - this information is used for your baby's legal birth certificate.

**My Birth Plan (optional)** - a birth plan can help you make special plans of your baby's birth. We will follow your wishes as much as we can provided that you and your baby are not at risk.

**Infant Photographic Release** - we offer professional photography services and the opportunity to place photos of your baby on our Web site. A photographer will meet with you to explain these services when you are admitted to North Memorial.

**This form should be completed and RETURNED 6 TO 8 WEEKS PRIOR to your due date:**

**Pre-Admission Registration** - pre-registration is recommended in order to ease your admission into the medical center. If you have any questions about this form, please call (763) 520-5376. **You can return this form by using the postage paid mailer or fax to (763) 520-1454.**

There is an additional cost of approximately \$60 for a private room, which may not be covered by insurance. You are required to pay the difference in cost between the private room rate and the amount paid by your insurance company. We cannot guarantee a private room. However, we will try to honor your request.

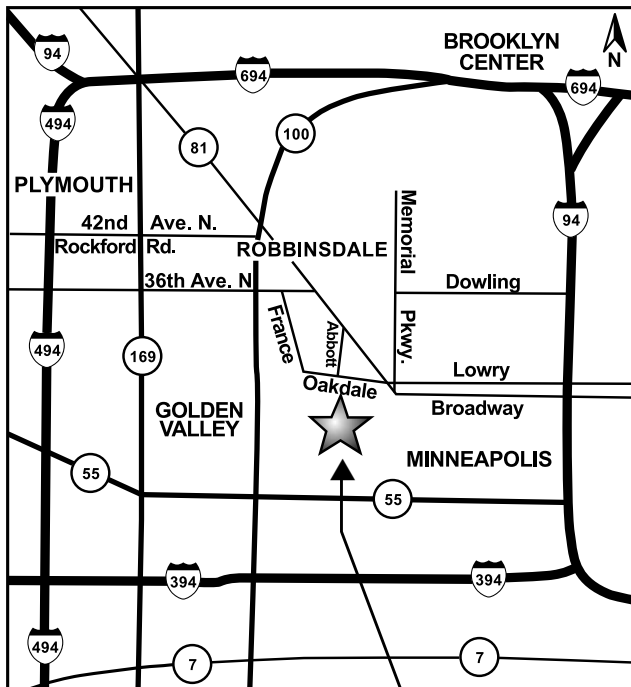
If you have any questions about our programs and services, our Birthing Advocate is available to help you.

|                                     |                |
|-------------------------------------|----------------|
| Birthing Advocate and Daytime Tours | (763) 520-1366 |
| Evening Tours & Class Information   | (763) 520-5830 |

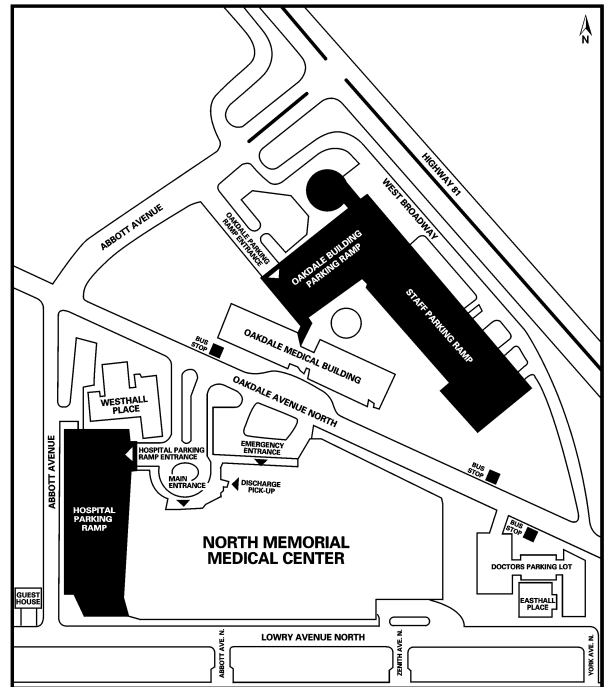
For more detailed information regarding our services, visit our Web site at:

[www.northmemorial.com](http://www.northmemorial.com)

WHEN THE TIME ARRIVES FOR THE BIRTH OF YOUR BABY, THE EMERGENCY ROOM ENTRANCE IS OPEN 24 HOURS A DAY OR YOU MAY ENTER THE HOSPITAL FROM THE HOSPITAL PARKING RAMP. ALL OTHER DOORS ARE LOCKED AT 8 P.M.



**North Memorial Location**



**North Memorial Campus**



**North Memorial  
Medical Center**

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## BIRTH CERTIFICATE INFORMATION

**PLEASE PRINT CLEARLY, THIS INFORMATION WILL BE TRANSFERRED TO YOUR BABY'S BIRTH CERTIFICATE. BRING THIS FORM WITH YOU AND GIVE IT TO YOUR LABOR NURSE.**

|  |  |  |   |   |
|--|--|--|---|---|
| MOTHER'S PRESENT NAME (First, Middle, Last)  |  | SS#  | MAIDEN SURNAME  | DATE OF BIRTH (Month, Day, Year)  |
| BIRTHPLACE (State or Foreign Country)  | RESIDENCE OF MOTHER (state in which she now lives) |  | COUNTY  | CITY, SUBURB OR TOWNSHIP IN WHICH YOU ACTUALLY LIVE (Do not confuse this with your mailing address) |
| STREET AND NUMBER  |  | INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input type="checkbox"/> NO | MOTHER'S MAILING ADDRESS (if same as residence, enter ZIP only)                 |   |
| FATHER'S NAME (First, Middle, Last)  |  | SS#  | DATE OF BIRTH (Month, Day, Year)  | BIRTHPLACE (State or Foreign Country)   |
| MOTHER'S MARITAL STATUS AT TIME OF THIS CHILD'S BIRTH<br><input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED |  |  | IF DIVORCE IS FINAL, IS IT 10 MONTHS OR LESS AT THE TIME OF THIS CHILD'S BIRTH? |   |
| OF HISPANIC ORIGIN? (Specify No or Yes - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  | RACE - American Indian, Black, White, etc. (Specify below)                     |   | EDUCATION (Specify only highest grade completed)  |
|  |  |  |   | ELEM./SEC (0-12)      COLLEGE (1-4 or 5+)   |
| MOTHER<br><input type="checkbox"/> No <input type="checkbox"/> YES (Specify)   |  | MOTHER   |   | MOTHER  |
| FATHER<br><input type="checkbox"/> No <input type="checkbox"/> YES (Specify)   |  | FATHER   |   | FATHER  |

|   |          |   |            |                               |  |                                     |
|---|----------|---|------------|-------------------------------|--|-------------------------------------|
| <b>LIVE BIRTHS</b><br>(DO NOT INCLUDE THIS CHILD) |          | OTHER TERMINATIONS (Spontaneous and induced at any time after conception) |            | DATE LAST NORMAL PERIOD BEGIN | MONTH OF PREGNANCY DOCTOR'S VISITS BEGAN | NUMBER OF VISITS (0, 1, 2, 3, etc.) |
|   |          | MISCARRIAGES ABORTIONS  | STILL BORN | MONTH      DAY      YEAR      | (1st, 2nd, etc.)<br>IF NONE, STATE SO    |                                     |
| NOW LIVING  | NOW DEAD | NUMBER  | NUMBER     | MOTHER'S PHONE NO.            |  |                                     |
| DATE OF LAST LIVE BIRTH (Month, Day, Year)        |          | DATE OF LAST OTHER TERMINATION (Month, Year)                              |            |                               |  |                                     |

**TO BE FILLED OUT BY THE NURSE AT THE TIME OF DELIVERY:**

|   |              |  |                                |                                    |      |                    |       |
|---|--------------|--|--------------------------------|------------------------------------|------|--------------------|-------|
| CHILD - NAME  |              |  | FIRST                          | MIDDLE                             | LAST | DATE OF BIRTH      | HOUR  |
|   |              |  |                                |                                    |      | MONTH   DAY   YEAR |       |
| SEX   | BIRTH WEIGHT |  | DOCTOR'S ESTIMATE OF GESTATION |                                    |      | APGAR SCORE        |       |
|   |              |  |                                |                                    |      | 1 MIN              | 5 MIN |
| DELIVERING DOCTOR   |              |  |                                | BABY'S DOCTOR                      |      |                    |       |
| BIRTH CERTIFICATE SENT                                      |              |  |                                |                                    |      |                    |       |
| DECLARATION OF PARENTAGE<br><input type="checkbox"/> COPIED |              |  |                                | 72 HOUR REPORT OF BIRTH TO A MINOR |      |                    |       |
|   |              |  |                                | DATE SENT                          |      |                    |       |



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## MY BIRTH PLAN

Fill out your birth plan and bring it with you when you come to North Memorial Medical Center for the birth of your baby. This will help your care providers, family and partner understand what is important to you. We will follow your wishes as much as we can provided that you and your baby are not at risk.

**Your Name:** \_\_\_\_\_ **Your Partner's Name:** \_\_\_\_\_

**Due Date:** \_\_\_\_\_ **Care Provider's Name:** \_\_\_\_\_

We plan to have the following people present at our birth: \_\_\_\_\_

\_\_\_\_\_

Unless there are medical reasons not to, we would like: \_\_\_\_\_

\_\_\_\_\_

Unless there are medical problems, we would like to avoid: \_\_\_\_\_

\_\_\_\_\_

I have special cultural and/or spiritual needs such as: \_\_\_\_\_

\_\_\_\_\_

I need an interpreter to help me communicate (foreign language or signing): \_\_\_\_\_

\_\_\_\_\_

If a cesarean delivery is necessary, \_\_\_\_\_ will be present in the operating room.  
(Name of person you would like to be with you)

After the birth, we would like: \_\_\_\_\_

**For questions or concerns, please contact any of our birth advocates listed below:**

|                                     |                |
|-------------------------------------|----------------|
| Birthing Advocate                   | (763) 520-1366 |
| Parenting Education Coordinator     | (763) 520-5484 |
| Labor & Delivery                    | (763) 520-5570 |
| Maternity                           | (763) 520-5590 |
| Scheduled Tours & Class Information | (763) 520-5830 |
| Daytime Tours                       | (763) 520-1366 |

For more detailed information regarding our services,  
visit our Web site at:

**[www.northmemorial.com](http://www.northmemorial.com)**



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**INFANT  
PHOTOGRAPHIC  
RELEASE**

Mother's full name (print clearly): \_\_\_\_\_

Father's full name (print clearly): \_\_\_\_\_

North Memorial has contracted with a photography company to provide you with photography services. This form allows you to either grant permission to the company to take your baby's photograph, or refuse to grant that permission. This is not an order form, and does not obligate you to purchase photographs.

**I grant permission for my/our child or children to be photographed.**

I understand that the photography company may offer me the option of posting photographs on the company's Web site. If I decide to use the Web site option, I understand that the company will ask me to sign a separate consent for that purpose. I also understand that North Memorial is not affiliated with the photography company's Web site, and that any questions or problems I have with the Web site will be handled by the photography company.

**I do not want my/our child photographed.**

**By signing below, I release North Memorial, it's staff, officers, trustees, employees, and agents from any and all claims or liabilities that may arise out of or relate to the taking of photograph(s) in accordance with this consent form.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Department (check one): 4SW    3 West    NICU

Baby's first and middle name (print)

Date of Birth

[Redacted area for baby's name]

[Redacted area for date of birth]

File this form in the patient's medical record.



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COMPLETE AND RETURN 6 TO 8 WEEKS PRIOR TO YOUR DUE DATE

**PRE-ADMISSION REGISTRATION**

**MAIL - Peel off tape, fold  
and mail or**

**FAX - (763) 520-1454**

|  |  |                                       |  |                              |  |                         |  |
|--|--|---------------------------------------|--|------------------------------|--|-------------------------|--|
| DUE DATE                                   |  | DOCTOR OR MIDWIFE'S NAME              |  | OB CLINIC NAME               |  | PRIMARY CLINIC NAME     |  |
| PATIENT'S LEGAL NAME (Last, First, Middle) |  |                                       |  | PREVIOUS ADMISSION<br>YES NO |  | FORMER OR MAIDEN NAME   |  |
| ADDRESS                                    |  | CITY                                  |  | STATE                        |  | ZIP                     |  |
| PHONE - HOME                               |  |                                       |  | WORK                         |  | SOCIAL SECURITY NO.     |  |
| DATE OF BIRTH                              |  | MARITAL STATUS<br>SGL MAR WID DIV SEP |  | STUDENT<br>FT PT             |  | RELIGION                |  |
|  |  |                                       |  |                              |  | PATIENTS EMPLOYERS NAME |  |

**GUARANTOR (PERSON RESPONSIBLE FOR BILL)**

|                         |  |      |            |                     |  |       |     |
|-------------------------|--|------|------------|---------------------|--|-------|-----|
| NAME (Last, First M.I.) |  |      | SEX<br>M F |                     | RELATIONSHIP TO PATIENT (circle one)<br>Other Self Spouse Parent Grandparent |       |     |
| PHONE - HOME            |  | WORK |            | SOCIAL SECURITY NO. |  |       |     |
| ADDRESS                 |  |      | CITY       |                     | STATE  |       | ZIP |
| EMPLOYER - NAME         |  |      | ADDRESS    |                     |  | PHONE |     |

**NEXT OF KIN (SPOUSE, IF YOU ARE MARRIED)**

|                         |  |              |  |   |  |              |  |
|-------------------------|--|--------------|--|---|--|--------------|--|
| NAME (Last, First M.I.) |  | RELATIONSHIP |  | PHONE - HOME  |  | PHONE - WORK |  |
| BABY'S INSURANCE        |  |              |  | CIRCLE POLICYHOLDER OF BABY'S INSURANCE:<br>MOTHER FATHER OTHER _____ |  |              |  |

**INSURANCE INFORMATION - Please list all insurance. If both spouses work, insurance information on both parties is required.  
PRIMARY INSURANCE POLICYHOLDER (The patient's insurance is always primary)**

|                         |  |            |                         |   |       |       |     |
|-------------------------|--|------------|-------------------------|---|-------|-------|-----|
| NAME (Last, First M.I.) |  |            | RELATIONSHIP TO PATIENT |   |       |       |     |
| PHONE - HOME            |  | WORK       |                         | SOCIAL SECURITY NO.   |       |       |     |
| ADDRESS                 |  |            | CITY                    |   | STATE |       | ZIP |
| DATE OF BIRTH           |  | SEX<br>M F |                         | EMPLOYMENT STATUS<br>FT PT UNEMPLOYED                                 |       |       |     |
| POLICYHOLDER'S EMPLOYER |  |            | ADDRESS                 |   |       | PHONE |     |
| INSURANCE COMPANY NAME  |  |            | ADDRESS                 |   |       | PHONE |     |
| POLICY ID NUMBER        |  | GROUP #    |                         | PLEASE LIST ANY OTHER INSURANCE COMPANY/NAME LISTED ON INSURANCE CARD |       |       |     |

**SECONDARY INSURANCE POLICYHOLDER**

|                         |  |              |              |                                       |       |       |     |
|-------------------------|--|--------------|--------------|---------------------------------------|-------|-------|-----|
| NAME (Last, First M.I.) |  |              | RELATIONSHIP |                                       |       |       |     |
| PHONE - HOME            |  | WORK         |              | SOCIAL SECURITY NO.                   |       |       |     |
| ADDRESS                 |  |              | CITY         |                                       | STATE |       | ZIP |
| DATE OF BIRTH           |  | SEX<br>M F   |              | EMPLOYMENT STATUS<br>FT PT UNEMPLOYED |       |       |     |
| EMPLOYER - NAME         |  |              | ADDRESS      |                                       |       | PHONE |     |
| INSURANCE COMPANY NAME  |  |              | ADDRESS      |                                       |       | PHONE |     |
| POLICY NUMBER           |  | GROUP NUMBER |              |                                       |       |       |     |

**SELF PAY  YES (IF NO INSURANCE, PLEASE CONTACT THE CREDIT DEPARTMENT AT (763) 520-5400)**

**PLEASE BRING YOUR INSURANCE, HMO, MEDICARE, BLUE CROSS OR MEDICAID I.D. CARDS AT TIME OF ADMISSION.**

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the above named hospital to release the information requested on this form for the purpose of verifying insurance coverage

DATE \_\_\_\_\_, 19\_\_\_\_\_

SIGNED \_\_\_\_\_

PATIENT (PARENT IF PATIENT IS A MINOR)