Maternity Pre-Registration Information

Atrium Health Floyd
Now part of ADVOCATEHEALTH

Mandatory Patient Information (PLEASE PRINT)

Full Legal Name: First _____ Middle _____ Last _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____

Sex at Birth ☐ Male ☐ Female

Preferred Gender ☐ Male ☐ Female ☐ Female-to-female (FTM) / Transgender Male / Trans Man
☐ Male-to-male (FTM) / Transgender Female / Trans Female
☐ Genderqueer, neither exclusively male nor female
☐ Decline to answer

Preferred Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow

Preferred Language _____ OBGYN Name _____

Social Security Number _____ Primary Care Physician _____

Work Phone _____ Cell Phone _____

Employer _____

Email _____ Religious Preference _____

Due Date _____ Last Menstrual Period _____

Is it okay to list your admission in our public hospital directory? ☐ Yes ☐ No

Responsible Person (Please complete if the patient is under 18.)

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Gender ☐ Male ☐ Female Social Security Number _____

Work Phone _____ Cell/Home Phone _____

Employer _____

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Emergency Contact

Name _____ Relationship to Patient _____

Phone _____

Second Emergency Contact (not living in the home)

Name _____ Relationship to Patient _____

Phone _____

Insurance Information

Primary Insurance

Insurance Company Name _____ Subscriber Name _____

Date of Birth of Policy Holder _____

Member ID # _____ Group # _____

Second Insurance

Insurance Company Name _____ Subscriber Name _____

Date of Birth of Policy Holder _____

Member ID # _____ Group # _____

For all patients, a copy of your legal photo I.D. is required.

For all insured patients, a copy of your current insurance card (front and back) is required.

I certify that the above information is correct and accurate to the best of my knowledge.

Patient Signature _____ Date _____

Patient Representative Signature _____ Date _____

After your forms are submitted, a member of our Registration Staff will contact you for the next steps.

You may mail, fax or return this form in person with a copy of both sides of your health coverage card. For more information, call us at 706.509.5980.

Mail:
Atrium Health Floyd Medical Center
Main Admissions / Registration
PO Box 233
Rome, GA 30162 - 0233

Fax: 706.509.5991

In Person:
Visit the Guest Relations desk in the Atrium Health Floyd Medical Center Main Entrance Lobby
Monday through Friday between the hours 8:00 a.m. – 6 p.m.