Pre-Registration for Birth

Congratulations on your bundle of joy! Vail Health wants to make preparing for your hospital visit as easy and stress-free as possible. We understand that you want the best medical care available and that you want your birthing experience to be private and personal with individual attention to you and your family.

Our team is here to assist you in the preparations for your admission. It is important for you to fill out this pre-admission form and return it in a timely manner. You may drop it off at the Admissions Department inside Vail Health Hospital, fax to (970) 470-6635, email to centralsched@vailhealth.org or mail it to Vail Health Admissions, P.O. Box 40,000, Vail, Colorado 81658.

Our team will begin by contacting your insurance company to obtain your health benefits. The insurance verifier will also calculate your estimated patient liability based on your individual insurance coverage. Vail Health will share this information with you using your preferred method of contact listed on this form.

We are here to answer any questions you may have. Please contact us Monday through Friday, 8:00AM-4:30PM at (888) 652-7640 or (970) 777-2902.

Due Date:	**Physician Name:**

Patient Information: (Please Print)

Full Legal: Last Name	First	Middle	Maiden Name
Date of Birth	Birthplace (State or Foreign Country)		
Mailing Address	Street Address		
City	State	Zip Code	
Phone	Phone		
Marital Status	Social Security #		
Employer	Occupation	Business Phone	
Employer Address	City	State	Zip Code
Religious Preference			

Emergency Contact: (Please Print)

Full Legal: Last Name | First | Middle | Maiden Name

Mailing Address | Street Address

City | State | Zip Code

Phone | Phone

Date of Birth | Marital Status | Social Security #

Employer | Occupation | Business Phone

Employer Address | City | State | Zip Code

Insurance Information:

The patient's insurance should be listed as primary over a spouse's or parent's insurance. Please include:

- A copy of your insurance card, front and back

Primary Insurance:

Name of Primary Insurance

Name of Policyholder | Date of Birth for Policyholder

Policy Identification Number

Group Name | Group Number

Insurance Medical Claims Address

Insurance Provider Phone #

Secondary Insurance:

Name of Primary Insurance

Name of Policyholder | Date of Birth for Policyholder

Policy Identification Number

Group Name | Group Number

Insurance Medical Claims Address

Insurance Provider Phone #

Do you intend on adding your baby to your insurance policy? ☐Yes ☐No