+rmc Regional Medical Center

OB PRE-REGISTRATION FORM

TODAY'S Date: _____ DUE Date: _____

PATIENT INFORMATION

Name: _____

Address: _____ City/State/Zip: _____

County: _____

Home Phone: _____-_____-_____ Cell: _____-_____-_____ Work: _____-_____-_____

Leave Phone Message: Yes ☐ No ☐

DOB (MM/DD/YYYY): _____/_____/_____ SSN: _____-_____-_____

Marital Status: ☐ S ☐ M ☐ D ☐ W

Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

NEXT OF KIN

Name: _____ Relation to Patient: _____

Address: _____ City/State/Zip: _____

Home Phone: _____-_____-_____ Cell: _____-_____-_____ Work: _____-_____-_____

INSURANCE PRIMARY

Insurance Carrier: _____ Primary Insurer: _____

Address: _____ City/State/Zip: _____

Policy Number: _____ Group Number: _____

INSURANCE SECONDARY

Insurance Carrier: _____ Secondary Insurer: _____

Address: _____ City/State/Zip: _____

Policy Number: _____ Group Number: _____

Attending Provider: _____ **PCP:** _____
Primary Care Provider

EMAIL FORM TO: **rmcobpreg@regmed.com**
CALL TO PRE-REGISTER: **803-395-2739 Option 2**
FAX FORM TO: **803-395-4744**