

OB PRE-ADMISSION

Ridgeview requests that you complete the following pre-admission information 3 months prior to your due date.

Mail to: Ridgeview Patient Access Dept., 500 S. Maple Street, Waconia, MN 55387 **-OR- Fax to:** 952-442-6524
-OR- E-mail to: SDSPreReg@ridgeviewmedical.org If you have questions, call 952-442-8087 and select option 2.

All Information Must Be Filled in Below

Today's Date _____ Expected Due Date _____ Family Clinic _____
OB Clinic _____ Family Doctor _____
OB Doctor _____ Baby's Clinic _____
Baby's Doctor _____

Patient Information

Name: (Last): _____ (First): _____ (Middle): _____ (Maiden): _____
Mailing Address: (Street): _____ (City): _____ (State): _____ (Zip): _____ (County): _____
Primary Contact Phone #: _____ E-mail: _____
Marital Status: (please circle) S M W Sep D
Birthdate: _____ Age: _____ S.S. # (needed on birth certificate): _____
Employer (Name): _____ Work Phone #: _____
Religion (optional): _____ Church (optional): _____

Spouse/Partner Information

Name: (Last): _____ (First): _____ (Middle): _____
Address: _____ Home Phone #: _____
Birthdate: _____ S.S. # (needed on birth certificate): _____
Employer (Name): _____ Work Phone #: _____

Nearest Relative

(Name): _____ (Phone): _____ (Date of Birth): _____ (Relationship): _____

Other Emergency Contact

(Name): _____ (Phone): _____ (Date of Birth): _____ (Relationship): _____

Primary Insurance Company Name: _____ Insurance Ph #: _____

Claims Address: _____

Policyholder: (Name): _____ (Date of Birth): ___/___/___ (S.S. #): _____

ID/Policy #: _____ Group/Account #: _____

Policyholder's Employer Name: _____ Employer Ph #: _____

Employer Mailing Address: _____

Secondary Insurance Coverage? Yes ___ No ___

Baby's Primary Insurance Company Name: _____ Insurance Ph #: _____

Claims Address: _____

Policyholder: (Name): _____ (Date of Birth): _____ (S.S. #): _____

ID/Policy #: _____ Group/Account #: _____

Policyholder's Employer Name: _____ Employer Ph #: _____

Employer Mailing Address: _____

Baby Secondary Insurance Coverage? Yes ___ No ___

If your insurance company requires pre-certification, have you called them? Yes ___ No ___

Would you like to be contacted with an estimate of charges & benefits? Yes ___ No ___

I acknowledge that Ridgeview offers a patient portal through MyChart.
Information can be found here - <https://www.ridgeviewmedical.org/mychart/>.

Please check one (1) box: I request to be connected to the Ridgeview patient portal. E-mail address to receive a registration link: _____

I decline to use Ridgeview's patient portal at this time.