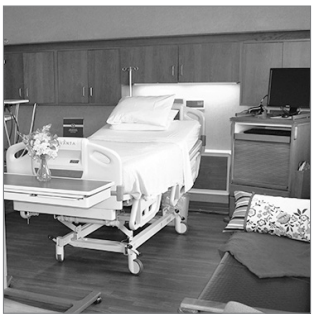

THE BIRTHPLACE AT DUPONT HOSPITAL

HELPFUL INFORMATION

Preregistering makes your admission process more efficient. Please complete the preregistration information and return it to Dupont Hospital, Attn. Registration, 2520 E. Dupont Road, Fort Wayne, IN 46825.

Preregistration information will be reviewed with you when you arrive at the hospital to deliver. If your address, telephone number or insurance information changes prior to delivery, please call (260) 416-3055. Making changes in advance will speed up the review process.

Check with your health insurance representative or employer to find out if authorization is required prior to hospitalization. This is your responsibility as the patient. Please notify your physician and complete the proper paperwork if authorization is required.

If you have health insurance, our business office will bill your insurance company. A financial counselor will also discuss your financial responsibility and make arrangements to collect any coinsurance, including co-pays and deductibles. If you do not have health insurance, please contact one of our financial counselors at (260) 416-3160 to review financial assistance programs offered by Dupont Hospital.

On delivery day, be sure to bring your

- photo ID (driver's license)
- Medicare/Medicaid card
- HMO card and/or any other healthcare insurance cards and policy numbers

Parking

The entrance to the Birthplace at Dupont Hospital is located to the left of the hospital's main entrance and leads directly to labor and delivery. There is no parking at this entrance, but there is free parking nearby. Free valet parking is available at the main entrance.

Lutheran Health Network
Dupont Hospital

2520 E. Dupont Road | Fort Wayne, IN 46825 | (260) 416-3000 | TheDupontDifference.com

REV. Feb. 2016

PREREGISTRATION INFORMATION

PLEASE PRINT CLEARLY

Lutheran Health Network
Dupont Hospital
2520 E. Dupont Road • Fort Wayne, IN 46825

DUE DATE _____

DOCTOR'S NAME _____
OB/GYN OR FAMILY PRACTICE

PATIENT INFORMATION

PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS

PATIENT NAME _____ MAIDEN NAME _____ SOCIAL SECURITY #_____

PATIENT ADDRESS _____ CITY _____ STATE/ZIP_____ COUNTY _____

PHONE # _____ EMAIL ADDRESS_____

DATE OF BIRTH _____ RACE _____

PATIENT EMPLOYER _____ EMPLOYER PHONE # _____

EMPLOYER ADDRESS _____ CITY _____ STATE/ZIP_____

OCCUPATION _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT_____ HOME/CELL/WORK # _____

EMERGENCY CONTACT EMPLOYER _____

2ND EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT_____ HOME/CELL/WORK # _____

INSURANCE INFORMATION

SUBSCRIBER NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER NAME _____ EMPLOYER ADDRESS _____ PHONE # _____

MEDICAID ID # _____ RECIPIENT NAME _____

PRIMARY INSURANCE COMPANY _____ SUBSCRIBER NAME _____

ID # _____ POLICY/GROUP # _____ PHONE # _____

SECONDARY INSURANCE COMPANY _____ SUBSCRIBER NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

ID # _____ POLICY/GROUP # _____ PHONE # _____