

701 Sixth Street South
St. Petersburg, Florida 33701-4891
(727) 823-1234

A subsidiary of Bayfront Health System



Dear Parent:

Bayfront Medical Center congratulates you on the upcoming birth of your baby and would like to take this opportunity to welcome you to Bayfront Baby Place. To ensure the admitting process goes as smoothly as possible, all obstetrics admissions are pre-registered.

The pre-registration information is included in this packet and must be completed prior to your stay.. Please fill in the required information and mail the forms, along with copies of your insurance card(s) to the admission department. We have included a postage-paid envelope for your convenience.

PRECERTIFICATION

Many insurance companies require that they be notified of your admission before your expected hospital stay. Please discuss this with your carrier and notify us of any authorization numbers that apply to your hospitalization. Failure to do this may result in a reduction of your benefits or even denial of benefits.

INSURANCE REMINDER

PLEASE NOTE, YOUR BABY NEEDS TO BE ADDED TO YOUR INSURANCE POLICY WITHIN 30 DAYS OF BIRTH. FAILURE TO ADD YOUR BABY TO YOUR INSURANCE POLICY CAN RESULT IN YOUR INSURANCE COMPANY DENYING PAYMENT TO THE HOSPITAL. IF THIS SHOULD OCCUR, YOU WILL BE RESPONSIBLE FOR THE HOSPITAL BILL.

FINANCIAL RESPONSIBILITY

Deposit may be requested prior to your admission to the hospital. If you need additional information, not already provided in your pre-admission packet, please contact our office at (727)290-1365, OB office.

Remember to pre-register as soon as possible. We appreciate the opportunity to care for you.

Thank You



St. Petersburg, Florida 33701

PRE-ADMISSION REGISTRATION FOR MATERNITY PATIENTS

Please complete the following and return to us in the self-addressed stamped envelope as soon as possible. By doing so, you will avoid having to answer these questions at an inconvenient time. This form will be on file in Labor & Delivery when you arrive.

Please fill out this form completely, and include ALL insurance or medical information. Thank You.

DO PARENTS OR PARENT WISH THEIR BABY'S ANNOUNCEMENT PUBLISHES IN THE NEWSPAPER YES NO

OB Doctor / Clinic Name:				Date Your Baby is Due:			
Baby's Pediatrician:				If you have other children, who is their pediatrician?			
PATIENT INFORMATION							
Last Name		First Name			M. Initial	Maiden Name	
Street Address		Apt No.	City		State	Zip	County
Home phone #	Birth Date	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Sex	Social Security No.		Are You an American Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status S M W D Separated		Religion		Occupation		Emp. Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Employer Name		Employer Address		City	State	Zip	Employer Phone
SPOUSE INFORMATION							
Last Name		First Name		M. Initial	Street Address		City
Home Phone	Social Security No.		Birth Date	Occupation		Employer Name	
Employer Address		City		State	Zip	Employer Phone No.	
EMERGENCY CONTACT INFORMATION (Not residing in the same household)							
Relationship to Patient	Last Name		First Name		Street Address		
Apt No.	City		State		Zip	Home phone	Work Phone
INSURANCE INFORMATION (List ALL insurance plans you will be using to cover your hospital stay)							
HMO <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No		PPO <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare #	Medicaid #
Name of Insurance Company #1		Name of Policyholder		Relationship to Patient		Policy No.	
Group No.	Employer Name		Insurance Co. Address		City	State	Zip
Insurance Co. Phone	Requires Precertification <input type="checkbox"/> Yes <input type="checkbox"/> No (If so contact certification no.)			Precertification phone # on card		Insurance Authorization #	
Name of Insurance Company # 2		Name of Policyholder		Relationship to Patient		Policy No.	HMO <input type="checkbox"/> Yes <input type="checkbox"/> No
Group No.	Employer Name		Insurance Co. Address		City	State	Zip
Insurance Co. Phone		Requires Precertification <input type="checkbox"/> Yes <input type="checkbox"/> No (If so contact certification no.)			Which Insurance Company will cover the baby?		

IMPORTANT: Any balance on your account that is not covered by your insurance company is due at the time of service. If you do not have any insurance, the hospital requires a deposit due on or before you are admitted. Please call 290-1365 to find out the amount of your required deposit. If you have any questions or problems, please feel free to call us. Thank You for choosing Bayfront Baby Place, we look forward to meeting and serving you.

PCS-N BMC# F-91240017 bg SK 3/10

PRE-ADMISSION REGISTRATION FOR MATERNITY PATIENTS

BAYFRONT BABY PLACE
BIRTH CERTIFICATE DATA SHEET
All Information is Confidential

The following information is needed to complete your baby's birth certificate. Due to Florida State guidelines, all birth certificates must be completed within 24 hours of the child's birth. Give this form to the clerk, who will prepare the birth certificate and will return to your room for verification and signature. The certificate will be forwarded to the Bureau of Vital Statistics. Bayfront Medical Center does not retain a copy of the birth certificate. Thank you for your assistance.

BABY'S INFORMATION

Child's Name: (First, Middle, Last) _____

Sex: _____ Date of Birth: _____ Birth Weight: _____ Time of Birth: _____ County of Birth: _____

Doctor or Midwife who delivered baby: _____

MOTHER'S INFORMATION

Maiden name: (First, Middle, Last) _____ Current Surname: _____

Marital Status: M S W D SEP Date of Birth: _____ Birthplace: (State/Country) _____

Residence: (State) _____ Residence: (County) _____ Residence: (City) _____

Street Address: _____

Is mailing address same as residence? If no provide address: _____ Live within city limits? _____

Education: 8th or less Some HS HS or GED Associates Degree Some College College Degree Masters Doctorate

FATHER'S INFORMATION

Name: (First, Middle, Last) _____

Date of Birth: _____ Birthplace: (State/Country) _____

Residence: (State) _____ Residence: (County) _____ Residence: (City) _____

Street Address: _____ Zip Code: _____

Education: 8th or less Some HS HS or GED Associates Degree Some College College Degree Masters Doctorate

Do you want to request a Social Security Card for this child? Yes No

Mother's Social Security number: _____

Father's Social Security number: _____

Principal source of payment: (please circle) Medicaid Private Insurance Self-Pay Other Unknown

Did you receive WIC food? Yes No

Were you transferred here from another birthing facility? Yes No

If yes, from where? _____

Was your infant transferred within 24 hours to All Children's Hospital? Yes No

INFORMATION FOR VITAL STATISTICS ONLY

MOTHER'S RACE: (please circle)

White Black American Indian or Alaskan Native (specify tribe) _____ Asian Indian Chinese Filipino
Japanese Korean Vietnamese Other Asian (specify) _____ Native Hawaiian Guamanian or Chamorro
Samoan Other Specific Islander (specify) _____ Other (specify) _____ Unknown
Hispanic Origin (please circle) Mexican Puerto Rican Central/South American Other Hispanic _____
Haitian Unknown

FATHER'S RACE: (please circle)

White Black American Indian or Alaskan Native (specify tribe) _____ Asian Indian Chinese Filipino
Japanese Korean Vietnamese Other Asian (specify) _____ Native Hawaiian Guamanian or Chamorro
Samoan Other Specific Islander (specify) _____ Other (specify) _____ Unknown
Hispanic Origin (please circle) Mexican Puerto Rican Central/South American Other Hispanic _____
Haitian Unknown

PREGNANCY HISTORY: Did you receive prenatal care? [] Yes [] No

Date of first prenatal visit: Month/Day/Year _____

Date of last prenatal visit: Month/Day/Year _____

Date of last menstrual period: _____

Number of prenatal visits: _____

Mother's Height: _____ Mother's weight: Pre-pregnancy _____ at delivery _____

Tobacco use during pregnancy? [] Yes, Avg. Per day _____ [] Yes but quit, Avg. Per day _____ [] No

Alcohol use during pregnancy? [] Yes [] No

How many other children do you have, excluding this child? _____

Birth date of last child, excluding this one: _____

Total number of miscarriages, stillbirths, and abortions _____

Date of last miscarriage, stillbirth, or abortion: _____

NEWBORN INFORMATION: Is infant being breastfed? [] Yes [] No

Estimate of gestational weeks at delivery (how far along were you at time of delivery?) _____

Help your baby have a healthy start in life! By Florida law, Healthy Start infant Risk Screening is offered to mothers of all newborn infants. You may be eligible for the Healthy Start Program or the Healthy Families Program. Eligibility is based on your answers to the question above, not on your financial situation. There are no fees for these services.

I am interested in having my infant screened for risk that could affect his/hers health or development in the first year of life. Yes ___ No ___

If my infant is referred, Healthy Start/Healthy Families may contact me. Yes ___ No ___

Current contact number () _____ - _____

I acknowledge that if I desire to change any information after the certificate is filed with the Office of Vital Statistics, I must assume full responsibility for all changes including any related fees.

I attest that the information recorded above is correct to the best of my knowledge.

Parent's Signature: _____ Date: _____



Important Phone Numbers

Main number:	727-290-1310
Antepartum:	727-290-1320
Labor and Delivery:	727-290-1330
Mom/Baby:	727-290-1340
Nursery:	727-290-1350
Admitting:	727-290-1365
Birth Certificate:	727-290-1369
Childbirth Education / Tea & Tour:	727-290-1310
Lactation Services:	727-290-1310

Bayfront Baby Place Website: www.bayfrontbabyplace.org



BIRTH ANNOUNCEMENT CONSENT FORM

Today's Date _____

Mothers Full Name _____

Fathers Full Name _____

(Please note: both Parents names are required. If parents are not legally married father Must sign below in order to be listed in the St. Petersburg Times.)

Married? (Check one): Yes _____ No _____

City of Residence: _____

Baby's Sex (check one): Male _____ Female _____

Baby's Weight: _____ lbs: _____ ounces

Date of Birth: _____ Time of birth: _____ indicate by circling AM or PM

Hospital where baby was born & city: _____

*Signature: _____
(If parents are not legally married father MUST sign.)

Telephone Number: _____

SOUTH Pinellas residents (including Seminole), return form to:
St.Petersburg Times, Birth Announcements/Obituary Desk
P.O. Box 1121, St.Petersburg, Fl 33731-1121
Tel: 727-896-8360 fax: 727-893-8632

NORTH Pinellas residents (Clearwater, Largo, etc.) return to
St.Petersburg Times, Att: Nova Beall
710 Court Streets, Clearwater, Fl 33756
Tel: 727-445-4176 fax: 727-445-4119

For Pasco or Hernando County residents: tel 727-869-6233 // fax 727-869-6233
For Hillsborough County residents: tel 813-226-3303 // fax 813-226-3381