HIGHLAND HOSPITAL
An Affiliate of the University of Rochester Medical Center

MEDICINE of the HIGHEST ORDER
1000 SOUTH AVE. • ROCHESTER, NY 14620 • (585) 473-2200

PLEASE ANSWER ALL QUESTIONS ON THE FRONT/BACK OF THIS FORM.
SURGICAL PATIENTS – BRING IN WITH YOU AT PRE-SURGICAL SCREENING
MATERNITY PATIENTS – RETURN IMMEDIATELY – ENCLOSED ENVELOPE

☐ SURGICAL PRE-ADMISSION

☐ MATERNITY PRE-ADMISSION
EXPECTED DUE DATE: _____

SURGICAL / MATERNITY PATIENT INFORMATION

PATIENT'S NAME: LAST / FIRST / MI			☐ MALE ☐ FEMALE	SOC. SEC. NUMBER:
DATE OF BIRTH:	AGE:	PLACE OF BIRTH (STATE):	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ LEGALLY SEP. ☐ WIDOWED ☐ DIVORCED	
MAILING ADDRESS:		CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	COUNTY:		
PATIENTS MOTHER'S NAME:		PATIENTS FATHER'S NAME:		
PATIENTS RACE:	PRIMARY LANGUAGE:	EMPLOYMENT STATUS: ☐ PART TIME ☐ FULL TIME ☐ RETIRED ☐ STUDENT		DATE OF RETIREMENT:
EMPLOYER/ SCHOOL:		WORK PHONE:		EXT.:
EMPLOYER'S ADDRESS:		CITY:	STATE:	ZIP CODE:
OCCUPATION:				

SPOUSE OR LEGAL RELATIVE INFORMATION FOR EMERGENCY CONTACT

RELATION:	NAME: LAST / FIRST		
SEX: ☐ MALE ☐ FEMALE	SOC. SEC. NUMBER:	DATE OF BIRTH:	AGE:
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
COUNTY:	HOME PHONE: / CELL PHONE:	EMPLOYER/ SCHOOL: / FT/PT	
EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP CODE:
WORK PHONE:	EXT.:	OCCUPATION:	

NEXT PERSON TO NOTIFY IN CASE OF AN EMERGENCY

RELATION:	NAME: LAST / FIRST		
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE: / CELL PHONE:	WORK PHONE:		EXT.:

OTHER MISCELLANEOUS INFORMATION

SURGEON: (or) OR/GYN PHYSICIAN:	PRIMARY CARE PHYSICIAN (PCP)		DATE SURGERY/ADMISSION SCHEDULED:
ADVANCED DIRECTIVES: DO YOU HAVE A HEALTH CARE PROXY? ☐ YES ☐ NO / DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO		IF YOU WERE A PREVIOUS HIGHLAND PATIENT ➤	DATE OF LAST ADMIT:
PREVIOUS NAME:			VETERAN: ☐ YES ☐ NO
CHURCH OR PARISH:	RELIGION:	CLERGY TO BE NOTIFIED ☐ YES ☐ NO	ROOM PREFERENCE: (FOR OVERNIGHT STAYS) ☐ PRIVATE ☐ SEMI-PRIVATE

FOR MATERNITY ADMISSION ONLY

PEDIATRICIAN:	FATHER'S NAME/ INFORMATION (if different):		FATHER'S DATE OF BIRTH:	
SOC. SEC. NUMBER:	ADDRESS:	CITY:	STATE:	ZIP:

FOR OFFICE USE ONLY

MOTHER CASE NO.:	ADMIT TIME:	NEWBORN SEX:	CASE NO.:		BIRTH WEIGHT:
ADMIT DATE:	ROOM NO.:	FIN. CL.: M: B:	DATE:	TIME:	CRIB NO.:

COMPLETE THE BACK PAGE ➤

NOTE: BRING YOUR INSURANCE CARD WITH YOU

INSURANCE INFORMATION (IF COVERED UNDER MULTIPLE INSURANCE PLANS, PLEASE LIST ALL INFORMATION)

- ☐ BLUE CROSS LOCAL/ROCHESTER
- ☐ BLUE CROSS OUT OF AREA
- ☐ BLUE CHOICE
- ☐ BLUE CHOICE OPTION
- ☐ BLUE CHOICE SENIOR
- ☐ MEDICARE BLUE CHOICE
- ☐ FAMILY HEALTH PLUS
- ☐ PREFERRED CARE MVP
- ☐ PREFERRED GOLD MVP
- ☐ PREFERRED OPTION MVP
- ☐ PREFERRED OPTION FAMILY MVP
- ☐ MEDICARE
- ☐ MEDICAID
- ☐ MOTOR VEHICLE
- ☐ WORKERS COMP
- ☐ OTHER (LIST NAME): _____

PRIMARY INSURANCE

NAME OF SUBSCRIBER/ MEMBER/POLICY HOLDER:	SUBSCRIBER DATE OF BIRTH:	IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
CONTRACT #/MEMBER ID # **(INCLUDE ALL LETTERS/#'S):**		
EFFECTIVE DATE:	GROUP #:	NAME OF INSURANCE:
ADDRESS OF INSURANCE PLAN:		

SECONDARY INSURANCE

NAME OF SUBSCRIBER/ MEMBER/POLICY HOLDER:	SUBSCRIBER DATE OF BIRTH:	IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
CONTRACT #/MEMBER ID # **(INCLUDE ALL LETTERS/#'S):**		
EFFECTIVE DATE:	GROUP #:	NAME OF INSURANCE:
ADDRESS OF INSURANCE PLAN:		

MEDICAID

CIN #/RECIPIENT NUMBER:	EFFECTIVE DATE:	COUNTY:

FOR TREATMENT RELATED TO MOTOR VEHICLE ACCIDENT/WORKERS COMP

INSURANCE COMPANY NAME:			PHONE NUMBER: ( )
ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURED:	POLICY #/WCB #/ CARRIER CASE:		IS PRE-ADMISSION CERTIFICATION REQUIRED: ☐ YES ☐ NO
INSURED EMPLOYER:			
EMPLOYER ADDRESS:	CITY:	STATE:	ZIP:
DATE OF ACCIDENT OR INJURY:	LOCATION:		
MOTOR VEHICLE INSURANCE COMPANY NAME:			
ADDRESS:	CITY:	STATE:	ZIP:

HOW WERE YOU FIRST INTRODUCED TO HIGHLAND HOSPITAL?

- ☐ BREAST CARE CENTER
- ☐ DIABETES HEALTHSOURCE
- ☐ FAMILY TIES (BABY CLUB)
- ☐ NEED-A-PHYSICIAN
- ☐ SENIOR HEALTHSOURCE
- ☐ WOMEN'S HEALTHSOURCE
- ☐ OTHER _____

WE WILL MAKE EVERY EFFORT TO PROVIDE THE ACCOMMODATION OF YOUR CHOICE. HOWEVER, ROOMS ARE ASSIGNED THE DAY OF ADMISSION AND DUE TO UNFORESEEN SHORTAGES OF BEDS, WE CANNOT GUARANTEE IN ADVANCE THAT YOU WILL RECEIVE THE ACCOMMODATION YOU PREFER. IF YOU HAVE REQUESTED A SEMI-PRIVATE ROOM AND NONE IS AVAILABLE THE DAY OF YOUR ADMISSION, WE WILL ASSIGN YOU TO A PRIVATE ROOM. THE ADDITIONAL CHARGE FOR A PRIVATE ROOM IS NOT COVERED BY MOST INSURANCE PLANS, THEREFORE YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. IF YOU HAVE ANY QUESTIONS PLEASE CALL THE BUSINESS OFFICE AT (585) 341-6536.

_____ SIGNATURE OF PERSON COMPLETING FORM

_____ DATE

PLEASE CHECK FORM FOR COMPLETENESS
SURGICAL PATIENTS – BRING IN AT PRE-SURGICAL SCREENING
MATERNITY PATIENTS – RETURN COMPLETED FORM IN ENCLOSED ENVELOPE

Strong Memorial Hospital Children's Hospital at Strong Highland Hospital
The Highlands Eastman Dental Center

Birth Certificate Worksheet

Please complete all information (type or print). Any Questions, call Birth Data at: 341-6837

Mother

Mother's Name: *First* *Middle* *Maiden Last Name* *Current Last Name*

Social Security Number	Mother's Date of Birth / /	Highest Grade Completed
City of Birth	State of Birth	If not USA, City and Country of Birth

Hispanic Origin: ☐ No ☐ Yes If Yes, Specify:

Race:

Residence Address: _____

County: _____ (circle one) City Town, or Village: _____ State: _____

Zip Code: _____ Phone Number: _____

Mailing Address (if different):

Employed While Pregnant: ☐ Yes ☐ No	Current / Most Recent Occupation	Kind of Business / Industry

Name of Company: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Month & Year of First Birth: ____ / ____ Month & Year of Last Birth Before This one: ____ / ____

Father

Father's Name: *First* *Middle* *Last Name* *Suffix*

Social Security Number	Father's Date of Birth / /	Highest Grade Completed
City of Birth	State of Birth	If not USA, City and Country of Birth

Hispanic Origin: ☐ No ☐ Yes If Yes, Specify:

Race:

Residence Address: ☐ Check if father's residence address is the same as mother's, otherwise enter below.

Street: _____

County: _____ City, Town, or Village: _____ State: _____

Zip Code: _____ Phone Number: _____

Current / Most Recent Occupation	Kind of Business / Industry

Name of Company: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Highland Hospital
1000 South Avenue Rochester, New York 14620 Phone: (585) 473-2200

THE MOST IMPORTANT DOCUMENT IN THE LIFE OF YOUR BABY

Your child's birth certificate is a very important document which provides proof of identity, age and nationality. From childhood through adulthood, information on the birth certificate will be needed for many important events such as: entrance to school; obtaining a work permit, driver's license or marriage license; entrance in the Armed Forces; employment; collection of Social Security and retirement benefits; and for a passport to travel in foreign lands.

Information on your baby's birth certificate also provides physicians and medical scientists with the facts about your child's health which may be useful in developing new maternal and child care programs for New York State.

Because the birth certificate is such an important document–both to you and your child–great care must be taken to make certain that it is correct in every detail. By completing the information on the back of this form and returning it to your physician or hospital, you can help us assure the accuracy of your baby's birth certificate.

Information on this form will be used to prepare the official birth certificate which is filed with the local Registrar of Vital Statistics of the city, town or incorporated village where the birth occurred and with the New York State Department of Health. When the filing process is completed, you will receive a certified copy of your child's birth certificate Copies of your baby's birth certificate may be obtained from your local registrar or the New York State Department of Health, Empire State Plaza, Albany, New York 12237-0023.

Please read all of the instructions and guidelines on this form. If you have a question, please contact your local registrar or the New York State Department of Health.

ESTABLISHING PATERNITY

MARRIED MOTHER

In New York State there is a legal presumption that a child is the legitimate offspring of the mother and the mother's husband. The husband's name should be entered as father of the child on the birth certificate if at the time of birth the mother is: a) Married or separated; b) Divorced, if the divorce was granted after conception; c) Widowed, if widowed after conception.

New York State Public Health Law, Section 4135.2 requires a determination of parentage by a court of competent jurisdiction to name someone other than the mother's husband as father of the child on the birth certificate. If a court determination cannot be obtained until after the birth certificate is filed, the State Health Department will prepare a new birth certificate upon receipt of a determination of parentage from the court.

UNMARRIED MOTHER

If the mother has never been married, a notarized paternity affidavit (Form DOH-2739 or its equivalent) signed by both the mother and the putative father is required to enter the putative father's name as father of the child on the birth certificate. A properly completed paternity affidavit is also required if, at the time of birth, the mother is unmarried and was divorced or widowed before conception. Paternity affidavits are available at your hospital.

If a paternity affidavit cannot be completed before the birth certificate is filed, the certificate must be filed with the father's name left blank. It may be added later by filing a notarized paternity affidavit (Form DOH-1927 or its equivalent) with the State Health Department. Form DOH-1927 is available from your local registrar of vital statistics or the State Health Department.

PLEASE DIRECT ALL CORRESPONDENCE CONCERNING COURT DETERMINATION OF PARENTAGE AND PATERNITY AFFIDAVITS TO: BIRTH AMENDMENTS UNIT, VITAL RECORDS SECTION, NEW YORK STATE DEPT. OF HEALTH, 733 BROADWAY, ALBANY, NY 12237-0023

CHILD'S SURNAME

MARRIED COUPLE

A married couple may select any surname for their child. They may choose the traditional paternal surname, the maternal surname, the maternal maiden name, a combination of paternal and maternal surnames (hyphenated or otherwise), a name derived from ethnic custom, a name unrelated to the parents, etc.

If there is a disagreement between the parents that cannot be resolved within the 5-day filing requirement, we recommend that you enter the husband's surname as the surname of the child. Advise the parents that they may change the child's name by court order.

If illegitimacy is alleged the mother may select the child's surname unless the husband objects. If the husband objects, enter his surname. The final choice of surname will be determined after the court rules on the child's paternity.

UNMARRIED MOTHER

The mother may select any surname that she wants for the child. She may even choose the name of the putative father regardless of whether or not he has signed a paternity affidavit.