

**THE BIRTH PLACE  
WOMEN'S RESOURCE OF ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, N.E.  
CONYERS, GEORGIA 30012**

**DEAR MOTHER TO BE,**

**THANK YOU FOR CHOOSING ROCKDALE MEDICAL CENTER FOR YOUR FUTURE DELIVERY.**

**WE HAVE FURNISHED YOU WITH A RESERVATION FORM TO BE COMPLETED AND RETURNED TO ROCKDALE MEDICAL CENTER. PLEASE COMPLETE THE FORM FULLY TO INSURE WE HAVE ALL YOUR INFORMATION AND TO REDUCE YOUR ADMISSION TIME WHEN YOU NEED TO COME IN FOR AN OB CHECK OR FOR DELIVERY. IF YOU NEED HELP COMPLETING THIS FORM PLEASE CALL LDRP ADMISSIONS OFFICE AT (770) 918-3675. ONCE YOU HAVE COMPLETED THIS FORM, PLEASE RETURN IT IN THE ENCLOSED, SELF-ADDRESSED, POSTAGE PAID ENVELOPE.**

**IF AT THE TIME YOU COMPLETE THIS FORM, YOU ARE UNINSURED PLEASE BE ADVISED WE HAVE ON-SITE FINANCIAL COUNSELORS THAT MAY BE ABLE TO GET FINANCIAL ASSISTANCE FOR YOUR VISITS TO THE HOSPITAL. THE PHONE NUMBER TO CONTACT IS (770) 918-3815.**

**WITH THE INFORMATION PROVIDED ON THIS RESERVATION FORM, WE WILL BE ABLE TO VERIFY INSURANCE ELIGIBILITY BENEFITS. ALSO, WE ASK THAT YOU NOTIFY YOUR INSURANCE COMPANY OF YOUR PREGNANCY TO INSURE MAXIMUM BENEFITS.**

**YOUR COOPERATION IS GREATLY APPRECIATED AND WE ARE HONORED TO BE A PART OF THIS TIME OF OUR LIFE.**

**PRIMARY INSURANCE CARRIER INFORMATION**

Primary Insurance Company Name: \_\_\_\_\_

HMO?: YES NO PPO?: YES NO

(If possible, please include a COPY of both sides of insurance cards)

INSURED PERSON'S NAME	RELATIONS TO PATIENT	INSURED EMPLOYER NAME	
BILLING STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE #	EFFECTIVE DATE	GROUP #	POLICY/CERTIFICATE #
DOES YOUR INSURANCE REQUIRE PRE-ADMISSION CERTIFICATION? YES NO	HAVE YOU CONTACTED YOUR INSURANCE COMPANY FOR CERTIFICATION? YES NO	PRE-CERTIFICATION APPROVAL # (IF OBTAINED):	PRE-CERTIFICATION PHONE #: BENEFIT VERIFICATION PHONE #:

**SECONDARY INSURANCE CARRIER INFORMATION**

Primary Insurance Company Name: \_\_\_\_\_

HMO?: YES NO PPO?: YES NO

(If possible, please include a COPY of both sides of insurance cards)

INSURED PERSON'S NAME	RELATIONS TO PATIENT	INSURED EMPLOYER NAME	
BILLING STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE #	EFFECTIVE DATE	GROUP #	POLICY/CERTIFICATE #
DOES YOUR INSURANCE REQUIRE PRE-ADMISSION CERTIFICATION? YES NO	HAVE YOU CONTACTED YOUR INSURANCE COMPANY FOR CERTIFICATION? YES NO	PRE-CERTIFICATION APPROVAL # (IF OBTAINED):	PRE-CERTIFICATION PHONE #: BENEFIT VERIFICATION PHONE #:

**MEDICAID INFORMATION**

(If possible, please include a COPY of both sides of insurance cards)

NAME AS IT APPEARS ON THE MEDICAID CARD	LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAID # ON CARD
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**PHYSICIAN / MISCELLANEOUS INFORMATION**

**PLEASE NOTE: Obstetrician and Pediatrician must be members of your insurance plan for maximum coverage**

OBSTETRICIAN	PEDIATRICIAN	PLANNED C-SECTION? YES NO	PLANNED STERILIZATION: YES NO
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**I HEREBY AUTHORIZE ROCKDALE MEDICAL CENTER TO CONTACT MY EMPLOYER OR INSURANCE COMPANY TO VERIFY INSURANCE BENEFITS AND RELEASE MEDICAL INFORMATION TO OBTAIN PRE-TREATMENT REQUIREMENTS**

Expectant Mother's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**PLEASE CALL ROCKDALE MEDICAL CENTER'S BIRTH PLACE AT 770-918-3675 IF ANY OF THE ABOVE INFORMATION CHANGES PRIOR TO YOUR DELIVERY OR IF YOU HAVE ANY QUESTIONS. WE LOOK FORWARD TO SHARING THIS VERY SPECIAL TIME IN YOUR LIFE!**



**Rockdale**  
 Medical Center  
 1412 MILSTEAD AVENUE, NE  
 CONYERS, GA 30012

**RESERVATION FOR DELIVERY**

**EXPECTED DELIVERY DATE:**

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MI	TITLE
MAIDEN NAME	BIRTH DATE	RACE	MARITAL STATUS S M W D SEP
STREET ADDRESS	CITY	STATE	COUNTY
APT/LOT#	ZIP CODE	PHONE #	SOCIAL SECURITY #
RELIGIOUS PREFERENCE	CHURCH / SYNAGOGUE		

**PATIENT EMPLOYER INFORMATION**

EMPLOYER NAME	STREET ADDRESS	CITY	STATE
ZIP CODE	PHONE #	OCCUPATION	EMPLOYMENT STATUS (please circle) FULL-TIME / PART TIME

**INSURED (PERSON OTHER THAN PATIENT RESPONSIBLE FOR BILL) INFORMATION**

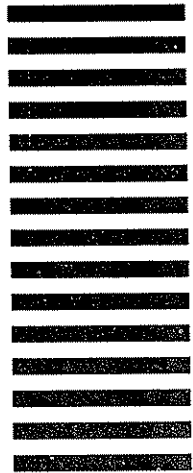
LAST NAME	FIRST NAME	GENDER	SOCIAL SECURITY #
STREET ADDRESS	CITY	STATE	COUNTY
ZIP CODE	PHONE #	RELATION TO PATIENT	
EMPLOYER NAME	STREET ADDRESS	CITY	STATE
ZIP CODE	PHONE#	OCCUPATION	EMPLOYMENT STATUS (please circle) FULL-TIME / PART TIME

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	RELATION TO PATIENT	
STREET ADDRESS	CITY	STATE	COUNTY
PHONE #	BIRTH DATE	SOCIAL SECURITY #	



NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES



**BUSINESS REPLY MAIL**  
FIRST CLASS      PERMIT NO. 10      CONYERS, GEORGIA

POSTAGE WILL BE PAID BY ADDRESSEE



ATTN: LDRP ADMISSIONS

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