REGISTRATION FORM

To the Patient: *Please complete this registration from, and return it to the hospital as soon as possible. A portion of this information is needed to complete your baby's birth certificate, therefore, accuracy is important. Please use current legal names in all cases. Thank you.*

Patient Last Name (Baby's Mother) First Middle	Maiden Name	Patient's Date of Birth	Patient's Social Security
		Patient's Place of Birth - City/Town, State/Country	
Patient Address – Street City State Zip		Have you ever received medical services at BWH? Y or N BWH Medical Record # (if known)	
Mailing Address (if different from above)		Home Telephone: Cell Phone:	
Patient Employer Name Address Phone		Patient Occupation	Date Baby is Due
Spouse/Significant Other First Name Middle Name Last Name	Spouse/Significant Other Occupation	Spouse/Significant Other's Date of Birth	Spouse Social Security
		Spouse/Significant Other's Place of Birth – City/Town, State/Country	
Spouse/Significant Other's Employer	Spouse/Significant Other's Business Telephone	Marital Status – **Please Circle One** Married Single Separated Divorced Widowed	
Primary Care Physician's Name and Address:	Prenatal Care Provider (obstetrician/midwife) If HVMA Prenatal Care, Which Site?	Name of Pediatrician/Group	Total # of pregnancies Including this one: / Total # of live births (do not include this child):
Next of Kin (in case of emergency) If other than spouse /significant other	Relationship to Patient	Next of Kin Telephone Number(s)	

Please provide your insurance information below ***If you have no insurance coverage, or questions regarding your coverage, please call us at (617) 732-4087 for assistance.***

Name of Insurance:_____ Subscriber's Name:_____ Subscriber's Relationship to Patient:_____

Policy/Subscriber/ID #_____ Group Name:_____ Group Number:_____

Address of Insurance Company_____ Insurance Company Telephone:_____

Person responsible for financial arrangements if other than patient, spouse or significant other:

Last Name First Name Middle	Address	
Employer's Name	Employer's Address	Employer's Telephone

The following information is confidential, and is not a part of your child's legal record. However, it is required by the Department of Public Health and is used for statistical and research purposes only.

During this pregnancy, how many cigarettes are you smoking per day? In the year before this pregnancy how many cigarettes were you smoking per day?

Education Level Attained by: **Where did you receive your highest level of education so far?** ☐ In the U.S. ☐ Not in the U.S. ☐ Declined (do not wish to provide)

Patient (baby's mother): Elementary or Secondary: 0 1 2 3 4 5 6 7 8 9 10 11 12; Diploma: Y N GED:_____ None:_____ College: 0 1 2 3 4 5 + Diploma: Y N

Baby's Father: Elementary or Secondary: 0 1 2 3 4 5 6 7 8 9 10 11 12; Diploma: Y N GED:_____ None:_____ College: 0 1 2 3 4 5 + Diploma: Y N

Over→

Brigham and Women's Hospital, in partnership with the State of Massachusetts and the Boston Public Health Commission, is interested in learning more about differences in health. We want to make sure that all our patients get the best care possible, regardless of their race or ethnic background. We would like you to tell us your race or ethnicity so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. The collection of this information is confidential and voluntary. It will not affect the delivery of services nor ever be used to discriminate in the provision of services.

I. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE? *You can choose more than one*

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race: _____
☐ Declined ☐ Unknown/Not Specified

II. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNICITY? *You can choose more than one*

☐ Afghanistani
☐ African
☐ African American
☐ American
☐ Andalusian
☐ Arab
☐ Argentinean
☐ Armenian
☐ Asian
☐ Assyrian
☐ Asturian
☐ Bahamian
☐ Bangladeshi
☐ Barbadian
☐ Belearic Islander
☐ Bhutanese
☐ Bolivian
☐ Botswanan
☐ Brazilian
☐ Burmese
☐ Cambodian (Kamupchean)
☐ Canadian
☐ Canal Zone
☐ Canarian
☐ Cape Verdean
☐ Caribbean Islander
☐ Carolinian
☐ Castillian
☐ Catalonian
☐ Central American
☐ Central American Indian
☐ Chamorro
☐ Chicano
☐ Chilean
☐ Chinese
☐ Chuukese
☐ Colombian
☐ Costa Rican
☐ Criollo
☐ Cuban
☐ Dominica Islander
☐ Dominican
☐ Eastern European
☐ Ecuadorian
☐ Egyptian
☐ English
☐ Ethiopian
☐ European
☐ Fijian
☐ Filipino
☐ French
☐ Gallego
☐ German
☐ Greek
☐ Guamanian
☐ Guatemalan
☐ Haitian
☐ Hmong
☐ Honduran
☐ Indian (Asian)
☐ Indonesian
☐ Iranian
☐ Iraqi
☐ Irish
☐ Israeili
☐ Italian
☐ Iwo Jiman
☐ Jamaican
☐ Japanese
☐ Kiribati
☐ Korean
☐ Kosraean
☐ La Raza
☐ Laotian
☐ Lebanese
☐ Liberian
☐ Madagascar
☐ Malaysian
☐ Maldivian
☐ Mariana Islander
☐ Marshallese
☐ Melanesian
☐ Mexican
☐ Mexican American
☐ Mexican American Indian
☐ Mexicano
☐ Micronesian
☐ Middle Eastern or North African
☐ Namibian
☐ Native Alaskan
☐ Native American
☐ Native Hawaiian or Other Pacific Islander
☐ Nepalese
☐ New Hebrides
☐ Nicaraguan
☐ Nigerian
☐ Okinawan
☐ Pakistani
☐ Palauan
☐ Palestinian
☐ Panamanian
☐ Papua New Guinean
☐ Paraguayan
☐ Peruvian
☐ Pohnpeian
☐ Polish
☐ Polynesian
☐ Portuguese
☐ Puerto Rican
☐ Russian
☐ Saipanese
☐ Salvadoran
☐ Samoan
☐ Scottish
☐ Singaporean
☐ Solomon Islander
☐ South American
☐ South American Indian
☐ Spaniard
☐ Spanish Basque
☐ Sri Lankan
☐ Syrian
☐ Tahitian
☐ Taiwanese
☐ Thai
☐ Tobagoan
☐ Tokelauan
☐ Tongan
☐ Trinidadian
☐ Uruguayan
☐ Valencian
☐ Venezuelan
☐ Vietnamese
☐ West Indian
☐ Yapese
☐ Zairean
☐ Other:_____

☐ Declined (do not wish to provide)
☐ Unavailable

III. IN WHAT LANGUAGE DO YOU PREFER TO COMMUNICATE (SPEAK) DURING MEDICAL APPOINTMENTS OR TO DISCUSS HEALTH RELATED INFORMATION?

☐ Albanian
☐ Amharic (Ethiopia)
☐ Arabic
☐ Armenian
☐ Bengali
☐ Bosnian
☐ Cambodian/Khmer
☐ Cape Verdean
☐ Chinese, Cantonese
☐ Chinese, Mandarin
☐ Chinese, Other
☐ Croatian
☐ English
☐ Farsi/Persian
☐ French
☐ German
☐ Greek
☐ Gujarati
☐ Haitian Creole
☐ Hebrew
☐ Hindi
☐ Italian
☐ Japanese
☐ Korean
☐ Laotian
☐ Polish
☐ Portuguese
☐ Russian
☐ Somali
☐ Spanish
☐ Tagalog
☐ Thai
☐ Tigrinya (Ethiopia)
☐ Turkish
☐ Ukranian
☐ Urdu
☐ Vietnamese
☐ Other Language:
_____
☐ Sign Usage (ASL)
☐ Sign Usage (Other):
_____
☐ Declined (do not wish to provide)
☐ Unavailable

IV. DO YOU PREFER TO HAVE WRITTEN MATERIALS IN THE SAME LANGUAGE IN WHICH YOU COMMUNICATE (SPEAK) DURING MEDICALAPPOINTMENTS OR TO DISCUSS HEALTH RELATED INFORMATION? ☐ Yes *☐ No

***IF YOU SELECTED NO, PLEASE INDICATE YOUR LANGUAGE PREFERENCE FOR WRITTEN MATERIALS:** _____