Forks Community Hospital

Childbirth Preparation Class Registration

Fax to (360)374-5220 or mail to Community Health 530 Bogachiel Way, Forks, WA 98331
Please include a copy of your insurance card (if any).

PARTICIPANT INFORMATION

Name: _____
LAST *FIRST* *MI*

Birth date: _____ **Marital Status**: S M D W **Social Security #**: _____

Mailing Address: _____ **Physical Address**: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail address: _____ **Race**: _____ **Religion:** _____

Employer: _____ **Occupation:** _____

Maiden Name: _____ **Other name(s) used:** _____

Prenatal Care Provider: _____ **Estimated Due Date:** _____

Birthing Coach/Partner: _____ **Relationship**: _____

PERSON RESPONSIBLE FOR PAYMENTS

Name: _____ **Relationship to participant:** _____

Mailing Address: _____ **Physical Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____

Social Security #: _____ **Race:** _____ **Religion:** _____

Primary Insurance

Please present insurance card or photocopy

Primary Policy_____

ID# _____ **Group#**_____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Secondary Insurance

Please present insurance card or photocopy

Secondary Policy_____

ID# _____ **Group#**_____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____