SAGUA MAÑAGU
Guam's First Birthing Center
PeMar Place, 472 Chalan San Antonio, Tamuning, GU 96913
Phone: 671.647.1417/1418 • Fax: 671.648.NANA (6262)
E-mail: info@saguamanagu-mpg.com

MR# _____

QS Entry_____Date/Initials

PRE-REGISTRATION

Please complete the information below and submit to ***Sagua Mañagu*** promptly, but no later than 37 weeks gestation.

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	EXPECTED DATE OF DELIVERY
PATIENT'S MAILING ADDRESS		CONTACT NUMBER(S) Home_____	NAME OF ATTENDING PHYSICIAN
RESIDENTIAL ADDRESS (If different from mailing)		Cell_____	NAME OF PEDIATRICIAN
DATE OF BIRTH MM/DD/YY	AGE (YEARS)	BIRTH PLACE	LAST FOUR DIGITS OF SS #
OCCUPATION (Title)	EMPLOYER	WORK PHONE NUMBER	EMAIL ADDRESS
HAVE YOU EVER BEEN A PATIENT AT THIS BIRTHING CENTER? YES ❒ NO ❒ If yes, give approximate date of last admission:		NAME AT FIRST ADMISSION (If different from current name)	

NAME OF SPOUSE or GUARANTOR (Other than patient}	DATE OF BIRTH	CONTACT NUMBER(S)	RELATIONSHIP TO PATIENT
MAILING ADDRESS(If different from patient mailing)		Home _____ Cell _____ Work _____	EMPLOYER

NOTIFY IN CASE OF EMERGENCY (Other than spouse}	RELATIONSHIP TO PATIENT	CONTACT NUMBER(S)
MAILING ADDRESS (If different from patient)		

INSURANCE INFORMATION

NAME OF INSURANCE (Primary)	POLICY NUMBER (Primary)	EFFECTIVE DATE
NAME OF POLICY HOLDER (If different from patient)	RELATIONSHIP TO PATIENT	CONTACT NUMBERS
NAME OF INSURANCE (Secondary)	POLICY NUMBER (Secondary)	EFFECTIVE DATE
NAME OF POLICY HOLDER (If different from patient)		ARE YOU ENTITLED TO MEDICAID OR MIP?

AUTHORIZATION TO RELEASE INFORMATION: I understand that I must also pre-register at the Guam Memorial Hospital (GMH) and I hereby authorize *Sagua Mañagu* to notify GMH when I deliver at the birthing center.

FINANCIAL PLAN: I understand that payment is expected prior to admission. I agree to pay my share of the fees for services rendered. I am also responsible for any and all additional fees and penalties, including pre-collection and post-collection expenses and interest that Sagua Mañagu or its authorized representatives may assess if I fail to meet the terms of my financial obligation.
I am aware that I must contact Sagua Mañagu's Patient Affairs at 647-1415 *before* my date of service if I have any questions regarding the fees or if I wish to make payment arrangements.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Spouse or Guarantor (Please Print) Date