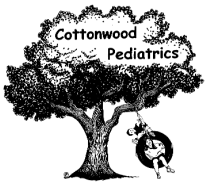

Note to Parents

Pre-registration Information

For Pediatric Coverage at Newton Medical Center

Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

Cottonwood Pediatrics sees all babies at Newton Medical Center, regardless of your planned follow-up physician.

- In the event of an emergency, one of our pediatricians will be at the delivery.
- If not needed at delivery, one of our pediatricians will still need to see your baby within the first 24 hours in the hospital and order required labs.

After you and your baby are dismissed, **your baby will need to be seen within 2 weeks** by your follow-up physician. We would be happy to see you – **all of our pediatric providers accept newborns**.

Pediatrician:
- ☐ Jon Jantz, MD
- ☐ Alyssa Watkins, MD
- ☐ Marla Kauffman, APRN

You may select a hospital pediatric provider and complete the following information.

Due Date: _____ OB _____ C-Section? ☐ Yes ☐ No ☐ Unknown

Sibling(s) ☐ None ☐ Yes; if so, please list _____

Parent Information **required information*

***Mother's Name** _____ ***Email** _____

Address (street, city, state, zip) _____ DOB _____

Home Phone _____ Other phone _____ SSN _____

Place of employment _____

Father's Name _____ ***Email** _____

Address (street, city, state, zip) _____ ☐ Same as Mother DOB _____

Home Phone _____ Other phone _____ SSN _____

Place of employment _____

Primary Insurance Information (*If child will have more insurance, please complete on other side*) → → → → → → → →

Insurance Company Name _____

Policy/ID # _____ Group # _____

Same as ☐ Mother or ☐ Father *above:*

Policyholder name _____

Policyholder's DOB _____ Policyholder's SSN _____

Policyholder's relationship to baby:
- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other _____

Policyholder's address (street, city, state, zip) _____

Policyholder's home phone _____ Other phone _____

Policyholder's employment _____

List additional insurance information on back – please provide complete information for all insurance policies covering the patient.

Please attach a copy of your insurance card(s)

Please List All Insurance Coverage that Applies to baby

Additional Insurance Coverage Information

Insurance Company Name ____________________

Policy/ID # ____________________ Group # ____________________

Policyholder name ____________________

Policyholder's DOB ____________________ Policyholder's SSN ____________________

Policyholder's relationship to baby:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other ____________________

Policyholder's address (street, city, state, zip) ____________________

Policyholder's home phone ____________________ Other phone ____________________

Policyholder's employment ____________________

Additional Insurance Coverage Information

Insurance Company Name ____________________

Policy/ID # ____________________ Group # ____________________

Policyholder name ____________________

Policyholder's DOB ____________________ Policyholder's SSN ____________________

Policyholder's relationship to baby:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other ____________________

Policyholder's address (street, city, state, zip) ____________________

Policyholder's home phone ____________________ Other phone ____________________

Policyholder's employment ____________________

Additional Insurance Coverage Information

Insurance Company Name ____________________

Policy/ID # ____________________ Group # ____________________

Policyholder name ____________________

Policyholder's DOB ____________________ Policyholder's SSN ____________________

Policyholder's relationship to baby:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other ____________________

Policyholder's address (street, city, state, zip) ____________________

Policyholder's home phone ____________________ Other phone ____________________

Policyholder's employment ____________________

Additional Insurance Coverage Information

Insurance Company Name ____________________

Policy/ID # ____________________ Group # ____________________

Policyholder name ____________________

Policyholder's DOB ____________________ Policyholder's SSN ____________________

Policyholder's relationship to baby:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other ____________________

Policyholder's address (street, city, state, zip) ____________________

Policyholder's home phone ____________________ Other phone ____________________

Policyholder's employment ____________________