

# pre-registration form

Please indicate at which hospital you plan to deliver:

Raleigh Campus       Cary Hospital

PATIENT'S NAME      LAST      FIRST      MIDDLE AND MAIDEN NAMES REQUIRED

MAILING ADDRESS

CITY/STATE/ZIP      COUNTY

PHONE      DAY      EVENING      SOCIAL SECURITY NUMBER

AGE      DATE OF BIRTH      RELIGIOUS PREFERENCE      PEDIATRICIAN

MARITAL STATUS       MARRIED       SINGLE       DIVORCED       WIDOWED       SEPARATED

RACE/ETHNICITY       ASIAN       NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER       BLACK/AFRICAN AMERICAN, NOT OF HISPANIC ORIGIN

HISPANIC OR LATINO       AMERICAN INDIAN OR ALASKA NATIVE       WHITE, NOT OF HISPANIC ORIGIN       OTHER

NAME OF SPOUSE      LAST      FIRST      MIDDLE

SPOUSE'S DATE OF BIRTH      SPOUSE'S SOCIAL SECURITY NUMBER

PARENT OR GUARDIAN NAME FOR PATIENTS UNDER 18 YEARS      PARENT OR GUARDIAN SOCIAL SECURITY NUMBER FOR PATIENTS UNDER 18 YEARS

PARENT OR GUARDIAN EMPLOYER FOR PATIENTS UNDER 18 YEARS

OBSTETRICIAN      MATERNITY DUE DATE      LAST MENSTRUAL PERIOD

HAVE YOU EVER BEEN ADMITTED TO WAKEMED (OR A DIVISION HOSPITAL)?       NO       YES, IF YES, UNDER WHAT NAME? \_\_\_\_\_

EMERGENCY CONTACT      NAME      RELATION TO PATIENT

ADDRESS      PHONE      DAY      EVENING

## EMPLOYMENT INFORMATION

PATIENT'S OCCUPATION      PATIENT'S EMPLOYER

EMPLOYER'S ADDRESS      EMPLOYER'S PHONE

SPOUSE'S OCCUPATION      SPOUSE'S EMPLOYER

EMPLOYER'S ADDRESS      EMPLOYER'S PHONE

## INSURANCE INFORMATION - PROVIDER NUMBER ONE PLEASE ENCLOSE A COPY OF INSURANCE CARD

INSURANCE NAME      EMPLOYER GROUP NUMBER

INSURANCE CLAIMS ADDRESS

INSURANCE PHONE      ID/POLICY NUMBER

NAME ON CARD      SOCIAL SECURITY NUMBER

SUBSCRIBER'S NAME      SUBSCRIBER'S DATE OF BIRTH

## INSURANCE INFORMATION - PROVIDER NUMBER TWO PLEASE ENCLOSE A COPY OF INSURANCE CARD

INSURANCE NAME      EMPLOYER GROUP NUMBER

INSURANCE CLAIMS ADDRESS

INSURANCE PHONE      ID/POLICY NUMBER

NAME ON CARD      SOCIAL SECURITY NUMBER

## MEDICAID

RECIPIENT NUMBER

\*CAROLINA ACCESS?       NO       YES, IF YES, NAME OF PRIMARY PHYSICIAN \_\_\_\_\_

I DO NOT HAVE HOSPITALIZATION INSURANCE OR OTHER AGENCY SPONSORSHIP, BUT WILL MAKE THE MINIMUM ADVANCE OF \$600 ON ADMISSION.

I HAVE NO INSURANCE AND AM NOT ABLE TO MAKE THE NECESSARY ADVANCE, BUT DESIRE TO MAKE ARRANGEMENTS BEFORE ANY ADMISSION TO THE HOSPITAL.

*Insurance pre-certification is the patient's responsibility.*