

Women's Pavilion & Birthplace
Pre-Registration Form

Raleigh Hospital Cary Hospital



*Insurance pre-certification is the patient's responsibility.
Please complete all of the fields below. **Highlighted fields** are needed for proper Pre-Registration.*

DOCTOR'S INFORMATION							
Obstetrician / Clinic	Primary Care Provider		Pediatrician		Maternity Due Date	Last Menstrual Period	
PATIENT INFORMATION							
Have you ever been to a WakeMed facility before? YES or NO				If YES, under what name?			
Last Name		Maiden Name		First Name		SSN	
Mailing Address					Home Telephone		
City					State	Zip Code	County
Age	Date of Birth			Religion Preference			
Marital Status:	Married	Single	Divorced	Widowed	Separated		
Race/Ethnicity:	Asian	Black – African American	American Indian	Other – Multi-racial, Mixed, Inter-racial	Pacific Islander	White	Decline / Chose not to answer
Are You of Hispanic Origin?	Yes	No	Decline / Chose not to answer				
EMERGENCY CONTACT							
Last Name			First Name			Relationship to Patient	
Address					Telephone		
Spouse Name			Spouse DOB			Spouse SSN	
For Patients Under 18 Years	Parent/Guardian Name		Parent/Guardian Name SSN		Parent/Guardian Name Employer		
EMPLOYMENT INFORMATION							
Patient's Occupation				Spouse's Occupation			
Patient's Employer				Spouse's Employer			
Employer's Address				Employer's Address			
Employer's Telephone				Employer's Telephone			
INSURANCE INFORMATION							
MEDICAID		YES or NO		Recipient Number			
CAROLINA ACCESS		YES or NO		Physician Name			
INSURANCE INFORMATION ****Please enclose a copy of your insurance card.****							
Insurance Name				Employer Group Number			
Insurance Claims Address							
Insurance Policy Number				Insurance Telephone			
Name on Card				SSN			
Subscriber's Name				Subscriber's DOB			