Johnston Health

Women's Pavilion Pre-Registration Form

For Office Use Only:

MRN: __________
Visit #: ___________
Registrar: ________

To prevent delays at the time of check-in, pre-registration is **recommended** at least two months before you pregnancy due date.

Please complete all of the fields below. Please fax a copy of your insurance cards and this form to our confidential fax number (919) 209-3513 or mail to the hospital in the envelope enclosed.

PATIENT INFORMATION

Patient's Last Name First Middle Initial		Mothers Name (identification purposes)	
Date of Birth (mm/dd/yyyy) / Marital Status / Social Security # / Race		Religion	Primary Language
Patient's Street Address	Apt. No.	City	Zip
Home Phone ( ) / Work Phone ( ) / Cell Phone ( )		Baby's doctor?	
Doctor's Last Name	First Name	Doctor Phone number	Estimated Due Date
Patient's Current Employer Name	Employer Address	City / State	Zip
Employer Phone ( )	Patient's Occupation	Employment Status: □ Not Employed □ Full Time □ Part Time □ Student □ Retired and Date:	
Full Name of Emergency Contact	Relationship	Home Phone ( )	Work Phone ( )
Have you ever been a patient at Johnston Health? □ Yes □ No		If yes, when was your last visit?	Under what name?

Guarantor or person responsible for bill

Last Name First Middle Initial		Relationship	Date of Birth (mm/dd/yyyy)
Street Address	Apt. No.	□ Female □ Male	Marital Status / Social Security No.
City / State / Zip	Home Phone ( )	Work Phone ( )	Cell Phone ( )
Employer Name	Employer Address	City	State / Zip
Employer Phone ( )	Occupation	Employment Status: □ Not Employed □ Full Time □ Part Time □ Student □ Retired and Date:	

Insurance Information

Primary Insurance Name			Name of Insured exactly as appears on card		
Insurance Billing Address		City	State	Zip	Phone No. ( )
Policy No. (for BCBS, include 3 letter prefix)	Group No.	Plan Code	State	Effective Date	Expiration Date

	Subscriber's Full Name	Subscriber's Soc. Sec. No.	Subscriber's Date of Birth (mm/dd/yyyy)	□ Female □ Male
	Subscriber's Employer name (if self-employed, company name)	Relation to Insured	Subscriber's Employment Status: □ Not Employed □ Full Time □ Part Time □ Student □ Retired and Date:	
	Subscriber's Employer Address	City	State Zip	Phone No. ( )

Secondary Insurance Information						
	Medicaid Number	Patient's name as appears on card		Effective Date		State
	Secondary Insurance Name			Name of Insured exactly as appears on card		
	Insurance Billing Address		City	State	Zip	Phone No. ( )
	Policy No. (for BCBS, include 3 letter prefix)	Group No.	Plan Code	State	Effective Date	Expiration Date
	Subscriber's Full Name		Subscriber's Soc. Sec. No.	Subscriber's Date of Birth (mm/dd/yyyy)	□ Female □ Male	
	Subscriber's Employer name (if self-employed, company name)		Relation to Insured	Subscriber's Employment Status: □ Not Employed □ Full Time □ Part Time □ Student □ Retired and Date:		
	Subscriber's Employer Address		City	State	Zip	Phone No. ( )

Self-Pay

* If you do not have insurance, please call our *Financial Counselors at 919-938-7138* before your scheduled arrival date to discuss financial options including our Financial Assistance Program which is available based on financial need eligibility.

Additional Information

Do you need special accommodations, such as Translation, Visual Aid, etc.? □ Yes □ No

*** If yes, please specify so that prior arrangements can be made for the day of your visit. ***

□ Language Interpreter ____________________ □ Sign Language Interpreter □ Visual aid □ Other: _______________

Patient Signature____**Date**____________________

Please fax or mail completed form with a copy of your insurance cards (front and back) at least two months prior to your due date.

Mailing address:
Johnston Health
Patient Access Department
509 N Brightleaf Blvd
Smithfield, NC 27577

Fax Number: 919-209-3513
Phone number: 919-209-3509
for questions or concerns.