Nash Health Care Women's Center Pre-Registration Form

Please note that while this form will help expedite the check-in process, you will still need to speak to a registration specialist when you arrive for delivery.

Online preregistration is an option available at nhcs.org/birth

Preregistration is recommended at 20 weeks of pregnancy or after.

1. Please complete all fields.
2. Please fax form and a copy of your insurance cards (both sides) to our confidential fax number 252.962.8956 or mail to :
   Nash Health Care
   Attention: Women's Center Registration
   2460 Curtis Ellis Drive
   Rocky Mount, NC 27804
3. If you have questions, please call the Women's Center at 252.962.BABY between the hours of 7 a.m. - 9 p.m., seven days a week.

Please note your insurance plan may require a co-payment, co-insurance or deductible. Your payment will be requested at the time of your visit. Nash Health Care accepts cash, personal checks and most major credit cards.
If you do not have insurance, please contact the financial counselor's office at 252.962.8034

Expected due date for birth of baby ______

Admitting Physician or Practice ______

Primary Care Physician ______

Women's Center Admission /Procedures

Check one
☐ Single Birth
☐ Twins
☐ Triplets
☐ Other (enter number) ______

Pediatrician ______

Race of Newborn ______

PATIENT IDENTIFICATION SECTION

Nash Health Care will compare your legal name to your legal identification card.

Patient's Legal Name (Last, First, Middle)

______
(As it appears on your legal ID)

Last 4 digits of Social Security Number ______

Birth date ______

Patient's Maiden Name (Last, First) ______

PATIENT INFORMATION

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Widow
☐ Divorced
☐ Other

Ethnicity
☐ Asian
☐ Black
☐ Caucasian
☐ Hispanic
☐ Indian

Mailing Address ______

______

City ______ State ______ Zip Code ______

Primary Phone ______

Alternate Phone ______

Primary Spoken Language ______

Church/Place of Worship ______

Religious Denomination ______

Email Address ______

Maiden Name of Patient's Mother (Last, First) ______

Do you have an Advanced Directive?
☐ Yes — Please bring it with you
☐ No

PATIENT'S EMPLOYMENT INFORMATION

EMPLOYMENT STATUS

- ☐ Full-Time
- ☐ Self-Employed
- ☐ Part-Time
- ☐ Unemployed
- ☐ Active Military
- ☐ Retired Military

Employer's Name

Employer's Address

City State Zip Code

Phone Extension

Name of Person Responsible for Bill

Relation to Patient

Last 4 Digits of Social Security Number

Sex Birth Date

Mailing Address

City State Zip Code

Home Phone

Employment Status

Employer's Name

Work Phone

EMERGENCY CONTACTS

Name

Relation to Patient

Mailing Address

City State Zip Code

Home Phone

Alternate Phone

Name of second contact

Home Phone

PRIMARY INSURANCE

Insurance Plan Name

Policyholder's Name

Patient's Relation to Policyholder

Policyholder's Birth Date Policyholder's Sex

Policyholder's Policy Number

Group Name (Employer Name)

Patient's Policy Number

Group Number

Customer Service Phone

Claim Address

City State Zip Code

SECONDARY INSURANCE

Insurance Plan Name

Policyholder's Name

Patient's Relation to Policyholder

Policyholder's Birth Date Policyholder's Sex

Policyholder's Policy Number

Group Name (Employer Name)

Patient's Policy Number

Group Number

Customer Service Phone

Claim Address

City State Zip Code

MEDICAID PATIENTS

Name of Cardholder

Medicaid Number

Current Month of Eligibility

Carolina Access Number

Physician

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE

Date Signed