Congratulations!

We are excited for you as you await and prepare for the arrival of your new baby.

We are glad you have chosen Betsy Johnson Regional Hospital for your delivery and we want to make your experience here as satisfying and easy as possible.

One of the ways we can be better prepared and help reduce annoying processes and procedures related to your hospitalization is by obtaining the registration information we need prior to your arrival at the hospital.

The enclosed form contains the most important information we need to be able to register you and your baby for services at Betsy Johnson Regional Hospital.

Please take a few minutes to complete this information. You may drop the completed form by the Patient Registration desk, or return it by mail to the following address: Betsy Johnson Regional Hospital
Attn: Patient Registration
P O Drawer 1706
Dunn, NC 28335

If you have questions about the registration process at Betsy Johnson Regional Hospital, please contact me. I would be happy to answer your questions and acquaint you with our hospital.

Thank you once again for choosing Betsy Johnson Regional Hospital for your healthcare services at this very special time.

Sincerely,

Nicole Barker

Nicole Barker
Patient Registration Supervisor
910-892-1000, Ext. 4049

BETSY JOHNSON REGIONAL HOSPITAL
OBSTETRICS PRE-REGISTRATION FORM

PATIENT'S NAME: ____

DATE OF BIRTH: __________ **MOTHER'S MAIDEN NAME:** ______________

MARRIED / SINGLE / DIVORCED / LEGALLY SEPERATED / WIDOWED

SOCIAL SECURITY #: ____________________ **RACE:** ___________________

PATIENT'S ADDRESS: ____

____

TELEPHONE #: ____

ALTERNATE #: ____

PATIENT'S EMPLOYER: ____

EMPLOYER ADDRESS: ____

____

EMPLOYER'S TELEPHONE #: _______________________________________

NEXT OF KIN: ____

ADDRESS: ____

____

TELEPHONE #: ___________________ **RELATIONSHIP:** ________________

PERSON TO NOTIFY: ____

ADDRESS: ____

____

TELEPHONE #: __________________ **RELATIONSHIP:** _________________

PRIMARY INSURANCE: ______________________________

POLICY#: ______________________ **GROUP #:** ____________

POLICYHOLDER'S NAME: ______________________________

POLICYHOLDER'S DATE OF BIRTH: ______________________
(IF PATIENT IS NOT THE POLICYHOLDER)

SECONDARY INSURANCE: ______________________________
(IF APPLICABLE)

POLICY #: ______________________ **GROUP #:** ____________

POLICYHOLDER'S NAME: ______________________________

POLICYHOLDER'S DATE OF BIRTH: ______________________
(IF PATIENT IS NOT THE POLICYHOLDER)

ESTIMATED DUE DATE: ______________________________

NAME OF OB/GYN DOCTOR: ______________________

<u>I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.</u>

SIGNATURE: ______________________________________

PRINTED NAME: ______________________ **DATE:** __________

IF ANY OF YOUR INFORMATION SHOULD CHANGE BEFORE YOUR DELIVERY, PLEASE BE SURE TO NOTIFY PATIENT REGISTRATION WITH THE UPDATED INFORMATION. WE MAY BE CONTACTED AT (910) 892-1000 EXTENSION 4063. THANK YOU FOR YOUR COOPERATION.