Rex Healthcare Women's Center Pre-Registration Form

Online preregistration is an option available at rexhealth.com/birth

To prevent delays at the time of check-in, preregistration is required at 20 weeks of pregnancy or after and no later than 30 days before your due date. If you are using the paper form:

1. Please complete all fields.
2. Please fax form and a copy of your insurance cards to our confidential fax number (919) 784-3445 or mail to :

   Patient Access
   Attention: Preregistration
   4420 Lake Boone Trail
   Raleigh, NC 27607

3. If you have questions, please call the Women's Center at (919) 784-3257 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. Rex Healthcare accepts cash, personal checks and most major credit cards.

Expected Date of Service (or 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) _____

Newborn physician _____ Race of Newborn _____

PATIENT IDENTIFICATION SECTION

Rex Healthcare will compare your legal name to your legal identification card.

Patient's Legal Name (Last, First, Middle) _____
(As it appears on your legal ID)

Sex _____ Last 4 digits of Social Security Number _____ Birth date _____

Patient's Maiden Name (Last, First) _____

PATIENT INFORMATION

Race _____ Marital Status _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Mailing Address _____

City _____ State _____ Zip Code _____

County _____ Country _____

Home Phone _____ Alternate Phone _____

Primary Spoken Language _____

Church/Place of Worship _____ Religious Denomination _____

Email Address _____

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

PATIENT'S EMPLOYMENT INFORMATION

Employment Status _____ Retirement Date (if applicable) _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Phone _____ Extension _____

GUARANTOR INFORMATION (Person Financially Responsible)

Name of Guarantor _____ 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 CONTACT

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Alternate 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 _____ Patient's Policy Number _____

Group Name (Employer Name) _____ 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 _____ Patient's Policy Number _____

Group Name (Employer Name) _____ Group Number _____

Customer Service Phone _____

Claim Address _____

City _____ State _____ Zip Code _____

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.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE _____

Date Signed _____