SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

PRE-REGISTRATION

254 Easton Avenue, New Brunswick, NJ 08901
732-745-8600
www.saintpetersuh.com

Please print clearly. Please present your insurance card(s) and any completed forms along with a form of address verification such as a driver's license upon registration/admission. Thank you for taking the time to complete this form.

SECTION 1 • PATIENT DATA:

Last Name: _____

First Name: _____

Home Address: _____

_____

Home Telephone: _____

Employer: _____

Employer Address: _____

_____

Employer Telephone: _____

Occupation: _____ ❑ FT ❑ PT ❑ Self-Employed

If Pregnant, Delivery Due Date: _____

Registration/Admission Date: _____

Physician: _____

Marital Status: ❑ Married ❑ Widowed ❑ Divorced ❑ Domestic Partner ❑ Separated ❑ Single

Sex: _____ Maiden Name: _____

Race: _____ Ethnicity: (See Reverse Side) _____

Date of Birth: _____ Soc. Sec. #: _____

Religion: _____

Place of Worship: _____

Location: _____

Do you have an **Advanced Directive for Health Care** ❑ YES ❑ NO

SECTION 2 • LEGAL NEXT OF KIN/EMERGENCY CONTACT:

Name: _____

Relationship to Patient: _____

Address: _____

_____

Telephone No: _____

Name/Emergency Contact if Different from Legal Next of Kin:

Relationship: _____

Address: _____

_____

Telephone No: _____

SECTION 3 • POLICY HOLDER/SECONDARY INSURER DATA:

If the patient is the policy holder and there is **no** secondary coverage please proceed to Section 4. If the primary insurer is someone other that the patient or if there is secondary coverage, please complete this section.

Policy Holder Name: _____

Address: _____

_____

Telephone: _____

Employer: _____

Employer Address: _____

_____

Relationship to Patient: _____

Social Security #: _____

Date of Birth: _____

Employer Telephone: _____

Occupation: _____ ❑ FT ❑ PT ❑ Self-Employed

SECTION 4 • INSURANCE POLICY(S) DATA:

PRIMARY COVERAGE:

Name of Insurance Co.: _____

Address of Insurance Co.: _____

_____

Telephone # of Ins. Co.: _____

Policy Holder: _____

ID# _____ Group # _____

Did you obtain a Precertification?

❑ YES ❑ NO Pre-Cert. #: _____

SECONDARY COVERAGE:

Name of Insurance Co.: _____

Address of Insurance Co.: _____

_____

Telephone # of Ins. Co.: _____

Policy Holder: _____

ID # _____ Group # _____

Did you obtain a Precertification?

❑ YES ❑ NO Pre-Cert. #: _____

The Hispanic Ethnicity codes as identified by the State of New Jersey, Department of Health, National Center for Health Statistics code are as follows:

0 = Non-Hispanic
1 = Mexican
2 = Puerto Rican
3 = Cuban
4 = Central or South American
5 = Other and Unknown Hispanic
9 = Not Classifiable

Notice to Deaf and Hard of Hearing Patients

You have a right to a Sign Language Interpreter if one is required for you to effectively communicate medical information with hospital staff. If you are deaf or hard of hearing and require a Sign Language Interpreter please let us know.