Dear Patient,

Thank you for choosing Chilton Medical Center for the birth of your baby. Please complete the following registration forms and return them as soon as possible. Your reservation will be activated upon receipt of your forms. If you have any questions, call the Access Center at 973.831.5010. We look forward to making this a memorable experience for you and your family.

Approximately two months prior to your due date, please come to the Access Center to sign your admission/consent forms. This will avoid any delay on the day you are in labor.

You will need to bring your insurance card(s) and government issued photo identification document such as a driver’s license, military identification, passport, permanent resident card, rest alien card (green card). The identification card may be issued by any government and need not be issued by the United States or a subdivision thereof.

The Access Center is open 6am to 5pm, Monday through Friday, and 7am to 12pm on Saturday.

Sincerely,

Kathleen Botbyl
Customer Service Coordinator, Access Center
Maternity Pre-admission Registration

Please print or type.

1. Patient’s name ____________________________ Last ___________ First ___________ Middle initial ___________

2. Maiden name _____________________________________________________________

3. Admitting physician _______________________________________________________

4. Family physician _________________________________________________________

5. Baby’s expected due date ___________________________________________________

6. Home phone (including area code) _____________________________________________

7. Street ____________________________ City ____________________________ State ________ Zip code ___________

8. Date of birth ___________________ Social Security number _______________________

9. Marital status: Married ___ Single ___ Widowed ___ Divorced ___ Legally separated ___

10. Religion _________________________ Church affiliation _______________________

11. Nearest relative

   Name ____________________________ Relation ____________________________

   Address ________________________________________________________________

   Phone number (Day) ____________________________ (Evening) ______________________

12. Whom to notify in emergency

   Name ____________________________ Relation ____________________________

   Address ________________________________________________________________

   Phone number (Day) ____________________________ (Evening) ______________________
Insurance Information

13. Self-pay: Yes ___ No ___

If yes, complete this form. Read and sign the release at the end of this registration form (no. 17). A Financial Counselor will contact you regarding payment. Also, complete the attached Newborn Registration form.

If no, continue below.

14. Does patient have insurance in her own name to cover this admission?
   Yes ___ No ___

Patient’s employer __________________________________________________________

Employer address __________________________________________________________________________________

Employer phone number _______________________________ Type of insurance _____________________________

ID number ___________________________________________ Verification phone number ______________________

15. Does spouse have insurance to cover this admission? Yes ___ No ___

If yes:

Spouse’s name ______________________________________________________________________________________

Date of birth _________________________________________ Social Security number _________________________

Employer ___________________________________________ Occupation __________________________________

Employer address __________________________________________________________________________________

Employer phone number _______________________________ Type of insurance _____________________________

ID number ___________________________________________ Verification phone number _____________________

16. Any additional hospital coverage? ________________________________________________________________

17. Please read and sign below.

I am aware that Chilton Medical Center will use this information to pre-verify my insurance coverage.

To the best of my knowledge, the attached information is complete and accurate.

Signature _________________________________________________________ Date ________________________

18. Would you like a Financial Counselor to contact you to discuss any concerns you may have regarding your hospital bill (payment plans, deposits, financial assistance)? Yes ___ No ___

Please complete the Newborn Registration form.
Newborn Registration

Please print or type.

1. Mother’s name ____________________________________________________________ Last  First  Middle initial

2. Mother’s Social Security number ____________________________________________

3. Will newborn be covered by insurance in mother’s name? Yes ___ No ___

   If yes, please supply mother’s:

   Date of birth ______________________________ Social Security number __________________________

   Employer ______________________________________ Occupation _______________________________

   Employer address _________________________________________________________________

   Employer phone number ______________________ Type of insurance _______________________

   ID number __________________________________ Verification phone number ____________________

4. Will newborn be covered by insurance in father’s name? Yes ___ No ___

   If yes, please supply father’s:

   Date of birth ______________________________ Social Security number __________________________

   Employer ______________________________________ Occupation _______________________________

   Employer address _________________________________________________________________

   Employer phone number ______________________ Type of insurance _______________________

   ID number __________________________________ Verification phone number ____________________

5. Have you chosen a physician to care for your baby? Yes ___ No ___

   If yes, please supply the physician’s name. _______________________________________________
Chilton Medical Center
97 West Parkway
Pompton Plains, NJ 07444

For a referral to an Atlantic Health System physician, call 1-800-247-9580 or visit atlantichealth.org