Chilton Medical Center
Maternity Pre-Admission Packet

Atlantic
Health System
Chilton Medical Center

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Chilton Medical Center

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

Chilton Medical Center
97 West Parkway
Pompton Plains, NJ 07444

Phone: 973.831.5000

Chilton
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ATLANTIC HEALTH SYSTEM

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.

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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. ______________________________

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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

WOMH-43384-21

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