



Name: \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (Middle)  
 DOB: \_\_\_\_\_ MR#: \_\_\_\_\_  
 Acct#: \_\_\_\_\_

**Pre-Registration Form - Child**  
 Return to NHRMC Business Center Annex  
 2001 S. 17th St. - Pre-Registration Dept.  
 Wilmington, NC 28402  
 By Fax: 910.667.7379

\*If a field is set as required, but does not apply to you, then please enter "N/A" in that field to indicate that it is not applicable.

Reason for Pre-Registration: \_\_\_\_\_ Other Reason: \_\_\_\_\_  
 Procedure: \_\_\_\_\_ CPT CODE: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ ICD-9 CODE: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Procedure Date: \_\_\_\_\_  
 Physician's Phone number: \_\_\_\_\_ Location: \_\_ Cape Fear Hospital \_\_ NHRMC 17th St.

Patient Information									
Patient Name: Last		First		Middle		Maiden / Previous Last Name(s)		Phone: (best number to reach you)	
Patient Home Street Address:				City, State, Zip:				County:	
Place of Birth	City, State	Date of Birth:	Age:	Sex:	Race:	Marital Status:	Religious Preference:	Social Security Number:	
Employer:			Occupation:				How Long?:		
Employment Status:		Employer's Address:						Work number:	
Parent or Guardian Name: Last		First		Middle		Maiden / Previous Last Name(s)		Social Security Number:	
Address: Street		City		State		ZIP		Home phone:	
Date of Birth:	Employer:			Occupation:			How Long?:		
Employment Status:		Employer's Address:						Work number:	
Emergency Contact:		Relationship to Patient?:		Address:				Phone number:	
Emergency Contact:		Relationship to Patient?:		Address:				Phone number:	

Insurance Information							
Name of Primary Insurance Company:		Policy Holder's Name:		Relation to Patient:		Policy Holder Date of Birth:	
Certificate or Policy ID Number:		Group Name:		Group Number:		Insurance Company Phone Number:	
Address to Send Hospital Claims: Street		City		State		ZIP	
Case Manager Name:			Pre-Authorization #:			Authorization Done by / Date:	
Name of Secondary Insurance Company:		Policy Holder's Name:		Relation to Patient:		Policy Holder Date of Birth:	
Certificate or Policy ID Number:		Group Name:		Group Number:		Insurance Company Phone Number:	
Address to Send Hospital Claims: Street		City		State		ZIP	
Case Manager Name:			Pre-Authorization #:			Authorization Done by / Date:	

NHRMC INTERNAL FORM - DO NOT RELEASE

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New Hanover Regional Medical Center

Check One  
 17th St. Campus  
 Cape Fear Campus

Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)  
DOB: \_\_\_\_\_ MR#: \_\_\_\_\_  
Acct#: \_\_\_\_\_ (NHRMC USE ONLY)

**SURGICAL REQUEST** For Posting by Fax, Fax (343-7490)

PATIENT NAME: Last First Middle Maiden/Previous Name(s)

DOB Age Race Sex Marital Status Social Security # MR #

Patient Home Address Phone (best number to reach you at)

City / State / Zip

Responsible Party Relationship Contact Phone

Procedure: \_\_\_\_\_ CPT CODE: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 CODE: \_\_\_\_\_

PRIMARY INSURANCE		SECONDARY INSURANCE	
Policy #		Policy #	
Policyholder	Relationship	Policyholder	Relationship
Group Name	Group#	Group Name	Group#
Pre-Auth#	Auth Done by / Date	Pre-Auth#	Auth Done by / Date
Case Manager	Phone#	Case Manager	Phone#
Claims Address		Claims Address	

NKDA  Latex Allergy  Private-ISOLATION  Private-LATEX Allergies: \_\_\_\_\_

Comments: (Special equipment, MD anesthesia, etc): \_\_\_\_\_

Physician/Surgeon: \_\_\_\_\_ Assistant Surgeon: \_\_\_\_\_ Physician's Office Contact/Tel#: \_\_\_\_\_

Please specify Patient STATUS  OR  Endoscopy;  Inpatient  ASU  Day of Surgery  Extended Recovery

Requested Procedure Date / Time \_\_\_\_\_ Requested Pre-Admission Testing Date / Time \_\_\_\_\_

Total Case Length: (check one)  30 min  45 min  1 hour  1.5 hours  2 hours  2.5 hours  3 hours  \_\_\_\_\_ hours

Anesthesia Type:  Axillary Block  Bier Block  Brachial Block  Cardial Block  Choice  ECT  Epidural  General  (LMA) Laryngeal Mask Airway  Local  (MAC) Monitored Anesthesia Coverage  None  Regional  Spinal

(FOR POSTING OFFICE USE ONLY)

POSTING OFFICE INITIALS \_\_\_\_\_ T NUMBER \_\_\_\_\_ / / \_\_\_\_\_ DATE POSTED

SURGICAL SCHEDULING (343-7287) / / \_\_\_\_\_ DATE FAXED

NHRMC INTERNAL FORM - DO NOT RELEASE



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