New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle)

DOB: _____ MR#: _____

Acct#: _____

Pre-Registration Form - TriCare, Champus, Champ VA

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: Inpatient Surgery 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: Single	Religious Preference:		Social Security Number:
Employer:		Occupation:						How Long?:
Employment Status: Full time	Employer's Address:							Work number:
Spouse 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: Unemployed	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: None	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

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 #	
				Single			

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 None	
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	

IF SCHEDULED BY PHONE DO NOT COMPLETE

☐ 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

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