RWJ ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL

One Robert Wood Johnson Place
P.O. Box 2601
New Brunswick, NJ 08901 / 732-828-3000
Admissions and Registration 732-937-8602

Ancillary Service: _____
Testing Date: _____
Family Physician: _____
Ordering Physician: _____
Diagnosis _____

OFFSITE PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL ____

SEX: ○ Male ○ Female MARITAL STATUS:_____ SS #:_____ - _____-_____

BIRTHPLACE:_____ DOB :_____HOME PHONE : _____

ADDRESS_____

CITY:_____STATE:_____ZIP CODE __:_____

EMPLOYER:_____POSITION:_____

LEGAL NEXT OF KIN (Legal Guardian, Spouse, Adult Child, Parent, Adult Sibling, Grandparent, Other_____

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL _____

STREET:_____ HOME PHONE :_____

CITY:_____ WORK PHONE: _____

ZIP CODE:_____ RELATIONSHIP TO PATIENT:_____

GUARANTOR INFORMATION PATIENT'S RELATION TO GUARANTOR:_____

LAST NAME:_____ FIRST NAME: _____ MIDDLE INITIAL _____

ADDRESS:_____

HOME PHONE: _____SEX: ○ Male ○ Female DATE OF BIRTH :_____

SS #:_____ OCCUPATION:_ _____

EMPLOYMENT STATUS:_____ EMPLOYER:_____

EMPLOYER ADDRESS:_____

DAYTIME CONTACT

NAME:_____ PHONE NUMBER:_____

**The State of New Jersey requires all hospitals to ask every patient admitted to the Hospital questions regarding their race and ethnicity.

RACE

- ☐**No, not Spanish/Hispanic/ Latino**
- ☐**Yes, Mexican, Mexican American, Chicano**
- ☐**Yes, Puerto Rican**
- ☐**Yes, Cuban**
- ☐**Yes, Central or South American**
- ☐**Yes, Other or South American**
- ☐**Unknown/Unabailable**

ETHNICITY

- ☐**White**
- ☐**Black or African American**
- ☐**American Indian or Alaska Native**
- ☐**Japanese**
- ☐**Korean**
- ☐**Vietnamese**
- ☐**Other Asian**
- ☐**Native Hawaiian**
- ☐**Guamanian or Chamorro**
- ☐**Samoan**
- ☐**Other Pacific Islander**
- ☐**Multiracial: White and Black or African American**
- ☐**Multiracial: White and American Indian or Alaskan Native**
- ☐**Multiracial: White and Asian**
- ☐**Multiracial: Black or African American and American Indian or Alaskan Native**
- ☐**Asian Indian**
- ☐**Chinese**
- ☐**Filipino**
- ☐**Other Race**
- ☐**Unknown/ Unavailable**

ACCIDENT ○ YES ○ NO IF YES, WAS IT ○ CAR ○ WORK Location, Date and Time of Accident:_____

PRIMARY INSURANCE INFORMATION PATIENT'S RELATIONSHIP TO INSURED _____

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL: _____

STREET:_____ HOME PHONE: _____

CITY:_____ STATE:_____ ZIP CODE:_____

SEX: ○ Male ○ Female DATE OF BIRTH:_____ SS #:_____

OCCUPATION:_____ EMPLOYMENT STATUS: _____

EMPLOYER:_____ EMPLOYER ADDRESS:_____

INSURANCE COMPANY NAME:_____

INSURANCE ADDRESS AND PHONE:_____

SUBSCRIBER #:_____ GROUP:_____ EFFECTIVE DATE:_____

SECONDARY INSURANCE INFORMATION PATIENT'S RELATION TO INSURER: _____

LAST NAME:__**Health**_____ FIRST NAME:_**Executive**_____ MIDDLE INITIAL: _____

STREET:_____**10 Plum Street**_____ HOME PHONE:_**732-253-3690**

CITY:_____**New Brunswick**_____ STATE**:**____**NJ**_____ ZIP CODE:___**08901**_____

SEX: ○ Male ○ Female DATE OF BIRTH:_____ SS #:_____

OCCUPATION:_____ EMPLOYMENT STATUS: _____

EMPLOYER:_____ EMPLOYER ADDRESS:_____

INSURANCE COMPANY NAME:_____

INSURANCE ADDRESS AND PHONE:_____

SUBSCRIBER #:_____ GROUP:_____ EFFECTIVE DATE:_____

DOES YOUR INSURANCE COMPANY HAVE ANY "PRE-CERTIFICATION" REQUIREMENTS? ○ YES ○ NO
IF YES, HAVE YOU MET THOSE REQUIREMENTS? ○ YES ○ NO

ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL DOES NOT DISCRIMINATE BASED ON RACE, COLOR, RELIGION, OR NATION OF ORIGIN

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