

TO BE MAILED

IMPORTANT RETURN PROMPTLY

HAVE YOU EVER BEEN REGISTERED UNDER A FORMER NAME AS AN INPATIENT OR OUTPATIENT AT ANY BARNABAS HEALTH HOSPITAL OR OUTPATIENT FACILITY? IF YES, PLEASE PROVIDE YOUR FORMER NAME:

Text input field for former name

DEMOGRAPHIC INFORMATION

Demographic information form with fields for patient and guarantor details, including names, addresses, phone numbers, and marital status.

THE STATE OF NEW JERSEY REQUIRES HOSPITAL TO REPORT STATISTICS REGARDING RACE AND ETHNICITY

Race and ethnicity reporting section with checkboxes for various categories like White, Black, Mexican, etc.

ADVANCE DEPOSITS WILL BE REQUIRED IF YOU ARE NOT FULLY COVERED BY INSURANCE YOU WILL BE ADVISED OF THE AMOUNT REQUIRED AFTER WE RECEIVE THIS FORM

ALL INSURANCE IDENTIFICATION CARDS WILL BE REQUIRED UPON ADMISSION. PLEASE HAVE THEM WITH YOU.

PLEASE PROVIDE PRIMARY AND SECONDARY INSURANCE INFORMATION BELOW.

Many health insurers require pre-authorization prior to admission. Please check your insurance booklet or card for the number to call, if applicable. Failure to comply with pre-authorization requirements can result in decreased benefits.

PLEASE CHECK YOUR PLAN PROVISIONS FOR ADDING THE BABY AFTER DELIVERY.

INSURANCE INFORMATION

Insurance information form with two sections for Coverage #1 and Coverage #2, including fields for insurance type, company name, member ID, and employment status.

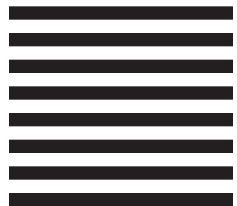
PRE-REGISTRATION FORM

Please complete this form and mail it in during your 7th month of pregnancy.
This will insure that your information is in our computer system.
Please note you will need to verify this information and sign in upon arrival.

FROM _____



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 156 LIVINGSTON, N.J.

POSTAGE WILL BE PAID BY ADDRESSEE

SAINT BARNABAS MEDICAL CENTER
OLD SHORT HILLS ROAD
LIVINGSTON, NEW JERSEY 07039-9960

ADMITTING OFFICE

