Raleigh Campus
3000 New Bern Avenue
Raleigh, NC 27610
Telephone: 919-350-8169
Fax 919-350-7811 or
email RaleighReg@wakemed.org

Cary Hospital
1900 Kildaire Farm Road
Cary, NC 27518
Telephone: 919-350-2523
Fax 919-350-2350 or
email CaryReg@wakemed.org

North Hospital
10000 Falls of Neuse Road
Raleigh, NC 27614
Telephone: 919-350-1581
Fax 919-350-9850 or
email northreg@wakemed.org

WakeMed

PRE-REGISTRATION FORM

Please complete all of the fields below. Please attach photo ID and copy of insurance card to this form.
Insurance pre-certification is the patient's responsibility.

DOCTOR'S INFORMATION

Obstetrician /Clinic	Primary Care Provider	Pediatrician	Maternity Due Date	Last Menstrual Period	Multiple Pregnancy ☐ Yes ☐ No

PATIENT INFORMATION

Have you ever been to a WakeMed facility before? ☐ Yes ☐ No If YES, under what name?

Last Name	First Name	Middle Name	Maiden Name	Preferred Name

Mailing Address			Telephone	
City		**State**	**Zip Code**	**County**
Age	**Date of Birth**	**Social Security Number**	**E-mail address**	

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Do you use MyChart Patient Portal? ☐ Yes ☐ No

Race/Ethnicity ☐ Asian ☐ Black-African American ☐ American Indian ☐ Other- Multi-racial, Mixed, Inter-racial ☐ Pacific Islander ☐ White ☐ Decline / Chose not to answer

Are you of Hispanic origin? ☐ Yes ☐ No ☐ Decline / Chose not to answer	Preferred Language	Religion Preference

EMERGENCY CONTACT

Last Name	First Name	Relationship to Patient
Address		**Telephone**
Spouse Name	**Spouse Date of Birth (DOB)**	**Spouse Social Security Number (SSN)**

For Patients under 18 years:	Parent/Guardian Name	Parent/Guardian SSN	Parent/Guardian	Parent/Guardian Employer

EMPLOYMENT INFORMATION

Patient's Occupation	Spouse's Occupation
Patient's Employer	Spouse's Employer
Employer's Address	Employer's Address
Employer's Telephone	Employer's Telephone

INSURANCE INFORMATION

MEDICAID ☐ Yes ☐ No	Recipient Number
CAROLINA ACCESS ☐ Yes ☐ No	Physician Name

INSURANCE INFORMATION **** Please include a copy of your insurance card. ****

Insurance Name	Employer Group Number
Insurance Claims Address	
Insurance Policy Number	Insurance Telephone
Name on Card	Social Security Number
Subscriber's Name	Subscriber's Date of Birth