Morristown Medical Center Maternity Pre-Registration Packet

Atlantic Health System
Morristown Medical Center

Atlantic
Health System
Morristown Medical Center

Dear Parent to be:

Thank you for choosing Morristown Medical Center to deliver your baby!

Our highly trained staff, along with your Obstetrician/Midwife and your pediatrician are here to make this a "special" delivery. There are several things you will need to do to help us get this journey on the road. First, we need to get you registered with the hospital. Below is a list of instructions to help you complete the attached file with all the forms. Once they are complete, you will need to return the file to us, either by US postal mail or email.

- Email address – **MATERNITY.REGISTRATIONMMH@ATLANTICHEALTH.ORG**
- Postal address – Morristown Medical Center / 100 Madison Ave. / Morristown, NJ / 07960
  Attention: Maternity Registration Interoffice Box 44

1. Complete the registration form and email it or mail it back

2. **It is very important you send a copy of the front/back of the patient's insurance cards and driver's license/passport in PDF format (if emailing back to us). Without it, we are unable to process your registration.**

3. The State of New Jersey mandates that every baby born in New Jersey be screened for multiple disorders that can cause serious health problems. **By signing this sheet, you are NOT giving permission for additional screening to be done but acknowledging we have given you the necessary information regarding necessary testing.** Should you choose to review the additional material on supplemental screening you can visit the websites provided on the notice.

4. **You will receive a second packet which includes the pediatrician form for you to fill out once we received the pre-registration paperwork.** Before you come to the hospital you MUST choose a pediatrician to care for your baby. We need to know who your pediatrician is upon your admission to assure your baby's metabolic testing results are sent to the right physician, post-discharge. If your chosen pediatrician does not have privileges in the newborn nursery, you may use our board-certified pediatric hospitalist.

5. Please feel free to contact the Pre-Registration office should you have any questions or concerns regarding your registration at 973-971-5732 or maternity.registrationmmh@atlantichealth.org

Thank You
The Maternity Center Staff

Advance Directives provided upon request.

MATERNITY REGISTRATION INFORMATION

Please have Photo ID and Insurance cards available

Email Address: ______________________

Obstetrician's Name: ______________________

Due Date: ______________________

Primary Care Doctor: ______________________

Patient Information

Patient Name: (Last, First, & MI)	Maiden name:	Sex: F M
Birthdate:	Social Security #:	Marital status: S W D M
Mailing Address:		Apt #:
City:	State/Zip Code:	
County:	Preferred Phone #:	
Race:	Nationality:	Can we leave a phone message?
Religion (optional):	Do you want a confidential address/phone?	
Faith Community/Congregation (optional):	Allergies:	
Do you have a living will? No Yes If yes, please enclose a copy.	Preferred Language:	

Alternate / Confidential Address

Resident Type: College Boarding school Relative's home Friend's home Shelter	
Address:	
City, State, & Zip code:	Can we mail to address?
Phone #:	Can we leave a phone message?

Patient's Employer Information

Are you employed: Not Employed Full time Pt time Student Self employed Military	
Employer/school name:	Patient Occupation:
Employer Address:	Work Phone #:
City:	State/Zip Code:

Significant Other / Spouse's Information

Name: (Last, First, & MI)	Relation to Patient:
Birthdate:	Social Security #:
Mailing Address:	Preferred Phone #:
City:	State/Zip Code:
Employment Status: Not Employed Full time Pt time Student Self employed Military	
Employer:	Occupation:
Mailing Address:	Work Phone #:
City:	State/Zip Code:

Notification in Case of Emergency (A second person to contact if desired)

Please notify: *(Name)*	Relation to Patient:
Address:	City, State, & Zip code:
Home Phone #:	Work Phone #:

Due to the multitude of variations with Insurance plans we cannot be responsible for knowing each individual patient's coverage plan. Therefore make sure that you familiarize yourself with your insurance plan, and keep us updated with any changes. If information is not received, incomplete, or inadequate we will have to register you as a "Self Pay Patient". This means you will be getting the bill from the hospital and will then have to submit the bill to your insurance company.

Primary Insurance Information		
Name of Insurance Company:		Insurance Plan:
Policy #:	Group #:	Relation to Insured: Patient Relative
Address:		Phone #:
City, State, & Zip code:		
Secondary Insurance Information		
Name of Insurance Company:		Insurance Plan:
Policy #:	Group #:	Relation to Insured: Patient Relative
Address:		Phone #:
City, State, & Zip code:		

Atlantic
Health System

DT1204

PATIENT ID
HERE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF AVAILABILITY OF SUPPLEMENTAL NEWBORN SCREENING

Notice of Availability of Supplemental Newborn Screening

Mandated Newborn Screening

New Jersey law mandates that every baby born in New Jersey receive:

- Newborn Biochemical (Bloodspot) Screening
- Hearing Screening
- Critical Congenital Heart Defect (pulse oximetry) Screening

For more information about the NJ Newborn Screening Program, see https://www.nj.gov/health/fhs/nbs/

Supplemental (additional, optional) Screening

The purpose of this notice is to inform expectant parents that New Jersey does not test for every possible birth defect and that additional, supplemental testing is available for defects for which the State does not screen, should you choose to pursue further screening.

- **Supplemental** screening is performed by private laboratories and may not be covered by your insurance plan.

The results of any supplemental screening tests are sent to the ordering health professional and NOT to the NJ Newborn Screening Program.

For more information about supplemental testing, visit:

https://www.babysfirsttest.org
https://babyfoodsteps.wordpress.com/babynewborn-screeningsteps/supplemental-newborn-screening/ *

For general information about Newborn Screening, see:

https://www.babysfirsttest.org/newborn-screening/screening-101 *

** The NJ Department of Health is not responsible for the content of these web pages.*

If you have any questions, please contact your health care provider.

Acknowledgment of Receipt of Notice of Availability of Supplemental Newborn Screening

By signing this form, I confirm that:

- My healthcare provider gave me the notice titled, “Notice of Availability of Supplemental Newborn Screening” and I kept a copy of the notice; and
- My health care provider gave me reasonable opportunity to read the notice and ask questions; and
- I understand that mandated newborn screening performed by the New Jersey Newborn Screening Laboratory will not detect all birth defects in infants for which tests are available; and
- I understand that I am personally responsible for the cost of additional, supplemental newborn screening laboratory services that I choose to pursue.

Relationship to Newborn (*check one*): ☐ Parent ☐ Guardian

Signature: ______________________ Date: __________ Time: __________

Print Name: ______________________

Witness Signature: ______________________ Date: __________ Time: __________

Print Witness Name: ______________________

The health care provider shall maintain the signed original of the acknowledgment. The health care provider shall give the signer a copy of this notice titled, “Notice of Availability of Supplemental Newborn Screening.”

SCH-7 JULY 2020

Morristown Medical Center
100 Madison Avenue
Morristown, NJ 07960

For a referral to an Atlantic Health System physician,
call 1-800-247-9580 or visit atlantichealth.org

MMC-43979-22

Atlantic
Health System
Morristown Medical Center