WakeMed

Outpatient Rehab Registration Form

Date of Initial Appointment: ________________________________
Patient Name: ________________________________ Date of Birth: ______________
SS#: ______-_____-_______ Age: ________ Race: ____________ Sex: _____ Marital Status: ___________
Home Phone: (___) ___________ Cell Phone: (___) ___________ Other Contact number: (___) ___________
Email address (Optional): ______________________________________
Mailing Address: ______________________________ City: ________________ State: _____ Zip: ______
County: _______________________
Physical Living Address (If different from above): ____________________ City: __________ State: ___ Zip: ______
County: _______________________

Patient Employee: _________________________________ Employer Phone: ______________________
Employer Address: ___________________________ City: ________________ State: _____ Zip: _______

Emergency Contact Person

Primary: ____ Relationship: _________________________

- Phone: 1) Home: _________________ 2) Work: _________________ 3) Cell or other: ________________

Secondary Emergency Contact Person: _______________________ Relationship: _____________________

- Phone: 1) Home: _________________ 2) Work: _________________ 3) Cell or other: ________________

Preferred language for health care information ____

INSURANCE DATA:

NOTE: You MUST bring valid insurance card to have claim submitted to Insurance Company.
Insurance Name: ____
Subscriber Employer (if different from above): _______________________________________
Subscriber's Name: ____________________ Date of Birth: __________ Relationship to patient: ____________

If not on insurance card:

Policy #: _____________________________ Group #: ________________________
Claims mailing address: ____
Phone number for customer service: ____________________________________ Date of Birth: ___________
Guarantor Name, if other than patient: _________________________________ Guarantor's SS#: _____________
Guarantor's Address: ____
Relationship to patient: ____
Guarantor's Employer: ____

Reason for your visit/diagnoses: ____
When did you start having these symptoms? ____

Referring Doctor's Name: ________________________________ Doctor's Phone Number: ________________
Family Physician: _____________________________________

ACCIDENT INFORMATION:

- **Were you in an auto accident?** ☐ Yes ☐ No:
  If yes, when and where (county or city) did the accident take place: _____________________________
  What is the name of the person responsible for the accident: ________________________________
  What type of auto insurance does the responsible party have? ________________________________
  Did a Police or Sheriff come to the scene of the accident? __________________________________
- **Is this a work related accident:** ☐ Yes ☐ No If yes, when did the accident happen? ________________
  Will you be filing a Liability Claim: ☐ Yes ☐ No If yes, please make sure this information is included in the insurance section of form.
  Name of contact person for Worker's Compensation: _______________________ Phone number: ___________
  Company's Name: ___________________________ Claim number for Worker's Comp: _________________

Patient's/Parent Signature: ____ Date: _________________

Form may be thinned from Patient's File

REV. 3/13 WMC-3116

Checklist for first Outpatient Rehab Appointment:

____ 1. Completed: *WakeMed Rehab Outpatient Services Intake Profile Form*
____ 2. Completed: *Outpatient Rehab Registration Form*
____ 3. Current Insurance Card
____ 4. Photo Identification (of patient if an adult or parent/legal guardian if patient is a minor)
____ 5. If not already faxed by doctor's office, please bring your signed *Physician/Doctor's Referral Form* (Date on the form must be less than 30 days from date of 1st rehab appointment)

Your physician may participate in a program that alerts them about your visit today. If your doctor has provided an email address for this purpose, may we notify him/her of your visit today? ☐ Yes ☐ No

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If there is anyone other than the patient that will be responsible for calling to make appointments, scheduling inquiries or to inquire on your progress, please let us know. A medical information release form is required if you are not the parent of a minor or legal guardian.

If you have a Health Care Power of Attorney form completed, please bring a copy of the official form and the information will be placed in your file. Thank you for choosing WakeMed and we look forward to exceeding your rehab needs.

For questions about the Rehab Registration Process, please call 919-350-4626.