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

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.