Rex Outpatient Rehabilitation of: ☐ Raleigh ☐ Wakefield ☐ Cary ☐ Garner
A Department of Rex Hospital

PLEASE PRINT PATIENT INFORMATION BELOW

PATIENT NAME (Last, First, Middle, Maiden)**: _____**

SSN: _____HOME ADDRESS: _____

CITY/STATE/ZIP: _____COUNTY: _____

HOME PHONE: _____ALTERNATE PHONE:_____ DOB:_____

SEX: _____ RACE: _____ MARITAL STATUS: _____ PRIMARY SPOKEN LANGUAGE: _____

MOTHERS NAME: _____ EMAIL:_____
MAIDEN, FIRST

EMPLOYER: _____ PHONE #_____

EMPLOYER ADDRESS: _____CITY/STATE/ZIP: _____

EMPLOYMENT STATUS: _____IF RETIRED GIVE RETIREMENTDATE:_____

PATIENT ENROLLED IN HOSPICE PROGRAM? ☐ YES ☐ NO

IS THIS SERVICE RELATED TO YOUR HOSPICE DIAGNOSIS? ☐ YES ☐ NO

GUARANTOR (Person responsible for account) **☐ SAME AS PATIENT**

NAME: _____RELATION TO PATIENT: _____
(MAIDEN)
SSN: _____ DOB: _____ MARITAL STATUS: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____COUNTY: _____

HOME PHONE: _____ MOTHERS NAME: _____

GUARANTOR EMPLOYER: _____PHONE #: _____

EMPLOYER ADDRESS: _____CITY/STATE/ZIP: _____

EMPLOYMENT STATUS: _____IF RETIRED GIVE RETIREMENTDATE: _____

EMERGENCY CONTACT

NAME: _____RELATION TO PATIENT: _____

HOME ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ALTERNATE PHONE: _____

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

TYPE OF ACCIDENT (AUTO, CRIME, WORK, OTHER): _____ACCIDENT DATE & TIME: _____

PLACE OF ACCIDENT & COUNTY: _____

DESCRIPTION OF ACCIDENT: _____