REX EXPRESS CARE

PATIENT REGISTRATION FORM

Patient Sticker

REASON FOR VISIT: _____

PATIENT INFORMATION (Rex Healthcare will compare your Legal Name to your legal identification card.)

Patient's Legal Name (Last, First, Middle) _____

Social Security #_____ Sex _____ Date of birth ___/____/_____ Marital Status _____

Address_____City_____State _____ Zip Code _____

Home Phone (____) _____Work (____) _____Mobile (____) _____

Email _____ County of Residence: _____

EMPLOYMENT Circle One: Full Time Part Time Retired Not Employed

Employer _____ If Retired/Date of Retirement _____

Address _____City _____State _____ Zip _____

GENERAL INFORMATION

Need Interpreter? YES / NO Preferred Language _____

Ethnicity: (PLEASE CIRCLE ONE) Hispanic/Non Hispanic/Other/Decline

Race: (PLEASE CIRCLE ONE) African American, Asian, Caucasian, Decline, Hispanic, Other

PRIMARY CARE PHYSICIAN

MD First and last Name _____

Practice Name _____ Phone (____)_____

Address _____

EMERGENCY CONTACT INFORMATION

Name _____Relationship to Patient _____

Address _____City _____State _____Zip _____

Phone Number (____) _____

EMERGENCY VISIT INFORMATION

ACCIDENT/INJURY : YES or NO Work Related : YES or NO

If Yes, please provide DATE_____PLACE _____ TIME _____

Brief Description of accident/injury _____

_____

GUARANTOR /RESPONSIBLE PARTY

Name (Last, First) _____ Date of Birth ____ / ____ / ____

Address _____City_____ Zip _____State _____

Phone: (___) _____ Employer & Work Phone # _____

Social Security # _____ Relationship to Patient _____

INSURANCE COVERAGE

PRIMARY INSURANCE

Insurance Name _____Social Security #_____

Subscriber/Policy Holder Name _____DOB ___/ ___ / _____

Address _____ City/State/Zip _____

Employer/Group Name _____ Relationship to Patient _____

SECONDARY INSURANCE

Insurance Name _____Social Security #_____

Subscriber/Policy Holder Name _____DOB ___/ ___ / _____

Address _____ City/State/Zip _____

Employer/Group Name _____ Relationship to Patient _____