

Sandhills Rehabilitation & Wellness Center, Inc.

239 W. Pennsylvania Avenue
Southern Pines, NC 28387

Patient Information Form

SRWC Chart #:

First Name		Middle Initial	Last Name		
Street Address		City		State	Zip Code
Mailing Address (if different from above)		City		State	Zip Code
Home Phone ()	Work Phone ()	Date of Birth	Age	Social Security #	
Marital Status M S D W	Gender Male Female	Employer or School/Address			
Family Physician:			Referring Physician		
Person to Contact in Case of Emergency		Relationship		Phone Number ()	
Spouse/Parent Name		Social Security #		Phone Number ()	
Spouse/Parent Address		City		State	Zip Code

Insurance Information

Insurance Company	Policy Number
Subscriber's Name	Subscribers Social Security # & DOB
Subscriber's Employer	
Secondary Insurance Company	Policy Number
Subscriber's Name	Subscribers Social Security # & DOB

Referring or Primary Care Physician Information

Name: _____	Telephone: _____
Address: _____	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability relating to such transmission of said records. I authorize my insurance carrier to make payment directly to **Sandhills Rehabilitation & Wellness Center, Inc.** I understand that I am responsible for any remaining balance due on my account not covered by my insurance carrier. Thus, if the account balance is not satisfied within 30 days after the first notification, the account may be referred for legal action. I consent to the treatment rendered to me under the general/special care of the attending rehabilitation specialist.

Signature _____ Date _____