SRWC
Sandhills Rehabilitation & Wellness Center
people helping people

Patient Information Form

SRWC Chart #:

Last Name	First Name		Middle initial
Street Address	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Email address	
Marital Status M ☐ S ☐ D ☐ W ☐	Parent Name (if the patient is a minor)		
Social Security Number	Date of Birth	Gender: Male ☐ Female ☐	
Employer or School			
Emergency Contact	Phone Number ( )	Relationship to patient	
Primary Care Physician	Phone Number ( )		

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____How did it happen? Auto ☐ Work ☐ Other ☐ State in which injury occurred_____

Claim Number _____Insurance Company (worker's comp or your auto PIP) _____

MEDICARE ONLY– *ADDITIONAL QUESTIONS*

If Medicare, are you currently receiving Home Health Service? Yes ☐ No ☐ If yes, Name of Agency? _____

If yes, what type of Home Health Services are you receiving? _____

INSURANCE INFORMATION — *PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING*

Primary Insurance	Policy Number	
Subscriber's Name	Subscriber's SSN	DOB
Subscriber's Employer	Employer Phone Number	
Secondary Insurance	Policy Number	
Subscriber's Name	Subscriber's SSN	DOB

I verify that the above information is accurate.

Patient's Signature _____ Date _____