VEREEN
REHABILITATION CENTER
SPORTS MEDICINE

WOUND CARE NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SSN: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Sex: M / F Marital Status: _____

Patient Employer Information

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Person to Contact in Case of Emergency

Name: _____ Relationship: _____

Address: _____ Phone: _____

Next of Kin □ *Same as Person to Contact (Above)*

Name: _____ Relationship: _____

Address: _____ Phone: _____

Guarantor Information (Required for Minors) □ *Same as Patient / Self*

Name: _____ Relationship: _____

Address: _____ Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Person(s) Authorized to Discuss Medical Information

_____

Primary Insurance Information

Insurance Company: _____

Address: _____

Group Name/Number: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Secondary Insurance Information

Insurance Company: _____

Address: _____

Group Name/Number: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Patient Medical History

Current Location of Pain: _____

Description of Pain (Duration, Intensity):

_____

Prior Treatment/Therapy for Pain:

_____

Injury?
Yes /// No
Workers Comp?
Yes /// No

Primary Care Physician: _____

Address: _____ Phone: _____

Referring Physician: _____

Address: _____ Phone: _____

Authorization and Release

I certify that I have accurately answered the above questions to the best of my knowledge. I authorize the Vereen Rehabilitation Center to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Vereen Rehabilitation Center any monies due. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

_____ _____

Signature of Patient *Date*

_____ _____

Signature of Parent/Guardian (If Patient is a Minor) *Date*