# REX SURGICAL SPECIALISTS

**PATIENT IDENTIFICATION**

**Patient's Legal Name** _____
(LAST) (FIRST) (MIDDLE)

**Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.**

Gender ____ Last 4 numbers Social Security# (some insurances require full SS) _____

Birth Date _____

**PATIENT INFORMATION**: Race_____Hispanic_____Non-Hispanic_____Language_____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Mobile Phone #_____Email Address_____

Referring Physician _____

Primary Care Physician_____

Other Physicians to Whom You Want Communication Sent _____ _____

**PATIENT EMPLOYMENT INFORMATION**

Status: Full-time ___ Part-time ____ Retired ____ Retirement Date _____ Full Time Student? Y/N Other_____

Employer's Name _____ Phone # _____

**GUARANTOR INFORMATION (Person Financially Responsible if different than patient)**

Name of Guarantor _____ Relationship to Patient _____

Last 4 Digits of Social Security # _____ Gender _____ Birth Date _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Employer's Name _____

**EMERGENCY CONTACT INFORMATION**

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Work Phone # _____Cell Phone # _____

**PRIMARY INSURANCE**

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

**SECONDARY INSURANCE**

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

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

Type of Accident (Auto, Work, Other) _____ Description_____

Accident Date and Time _____Place of Accident (City,County,State)_____

Patient/Authorized Representative Signature _____Date_____