CENTRAL PARK WEST REHABILITATION CENTER
PATIENT REGISTRATION

Account No:_____ **Date**:_____

_____ **Home Phone**: (____) ____-____
Last Name **First Name** **Initial** **Work Phone:** (____)____-____

_____ **Cell Phone**: (____)____-____
Street Address **E-mail:** _____

_____ **Sex**: M_☐_ F_☐_
City **State** **Zip Code**

Soc. Sec. No:_ _ _ - _ _ - _ _ _ _ **Status**: Single☐ Married☐ Other☐ **Birth Date**: ____ - ___ - ____
Mo **Day** **Yr**

IN EMERGENCY, PLEASE CONTACT:_____ **Phone**:(____)_____-_____

Referring Physician:_____ **Phone**:(____)_____-_____

Primary Care Physician:_____ **Phone**:(____)_____-_____

Date of Onset/Injury:_____-_____-_____ **Date of Surgery**: _____-_____-_____

Area of Body Injured:_____

Check One: Employed ☐ Full-time Student ☐ Part-time Student ☐ Other ☐

Place of Your Employment:_____

Address:_____
Street Address City State Zip Code

OCCUPATION:_____

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HOW DID YOU HEAR OF OUR FACILITY?
Doctor_☐_ Family/Friend_☐_ Yellow Pages_☐_ Other (Explain)_____

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IS THIS DUE TO AN ACCIDENT? NO_☐_ AUTO_☐_ OTHER(describe)_____
PRIMARY INSURANCE: MEDICARE_☐_ MEDICAID_☐_ WORKERS' COMP_☐_ PRIVATE_☐_
AUTO INS_☐_ OTHER_____

SECONDARY INSURANCE: NO_☐_ YES_☐_ (Specify)_____

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"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan or insurance company to Central Park West Rehabilitation Center."

"I consent to the treatment prescribed by my physician or as determined necessary by Central Park West Rehabilitation and agree to hold Central Park West Rehabilitation harmless of any complications whatsoever from such treatment, save negligence."

"I understand that I am financially responsible for all charges including any deductible, co-payments, or 'unusual customary rates' if not paid by said insurance, payable 30 days after billing."

"I acknowledge that I have received a copy of the **Notice of Privacy Practices** from Central Park West Rehabilitation Center."

Patient or Authorized Signature:_____ Date:_____

(If Other Than Patient, Print Name and Relationship)_____