Pre-Registration Form

To prevent delays at the time of check-in, pre-registration is required at least two business days before your pre-surgical testing visit or your date of service, only if:

- You are a new patient to Rex
- Your insurance information has changed since your last visit

Please select the facility that you are scheduled for the procedure/service:

☐ Rex Healthcare
4420 Lake Boone Trail
Raleigh, NC 27607
Phone #: 919-784-6138
Fax #: 919-784-6248

☐ Rex Healthcare of Wakefield
11200 Governor Manly Way, Suite 108
Raleigh, NC 27614
Phone #: 919-570-7508
Fax #: 919-570-7501

☐ Rex Healthcare of Holly Springs
781 Avent Ferry Road
Holly Springs, NC 27540
Phone #: 919-567-6110
Fax #: 919-567-6111

☐ Rex Healthcare of Knightdale
6602 Knightdale Boulevard
Knightdale, NC 27545
Phone #: 919-747-5200
Fax #: 919-747-5201

☐ Rex Healthcare of Cary
1515 SW Cary Parkway
Cary, NC 27511
Phone #: 919-367-2600
Fax #: 919-387-3145

For questions or if you wish to pre-register by phone, please call the Patient Access area at the location listed above.

***Please note that your insurance plan may require a co-payment, co-insurance or deductible; your payment will be requested at the time of your visit.**

Rex Healthcare accepts cash, personal checks, and most credit cards.

Type of Service / Reason for Visit

Expected Admit Date/Surgery Date _____

Please check the type of service(s) scheduled or planned:

☐ Cardiovascular Services
☐ Coagulation Services
☐ Diabetes Education
☐ Endoscopy Procedure
☐ Heart Catherization
☐ Heart and Vascular Diagnostics
☐ Hospital Admission
☐ Nuclear Medicine Services
☐ Preadmission Testing
☐ Radiology Diagnostics (CAT scan / MRI / X-ray / Digital Mammography / Bone Density / Ultrasound)
☐ Same Day Surgery
☐ Vascular Procedure

Please complete all fields

Patient Information

Patient's Legal Name (Last, First, Middle) _____

Sex _____ Last 4 Digits of Social Security # _____ Birth date _____

Race _____ Ethnicity ☐ Hispanic ☐ Non Hispanic

Marital Status _____

Mother's Maiden Name (Maiden Last, First) _____

Mailing Address _____

City _____ State _____ Zip Code _____

County _____ Country _____

Home Phone# _____ Alternate Phone # _____

E-mail Address _____

Primary Spoken Language _____

Church/Place of Worship _____

Religious Denomination _____

Employment Information

Employment Status _____ Retirement Date (if applicable) _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Phone # _____ Extension _____

Guarantor Information (Person Financially Responsible)

Name of Guarantor _____ Relation to Patient _____

Last 4 Digits of Social Security # _____ Sex _____ Birth date _____

Mailing Address _____

City _____ State _____ Zip code _____

Home Phone # _____ Work Phone # _____

Employment Status _____ Employer's Name _____

Emergency Contact

Name of Emergency Contact _____ Relation to Patient _____

Physical Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone# _____ Alternate Phone # _____

Please complete all fields

Medical Information

Admitting Physician _____

Referring Physician _____

Primary Care Physician _____

Are you enrolled in a Hospice Program? _____ Is this service related? _____

If yes, which Hospice agency _____

Accident Information

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

Type of Accident: ☐ Auto ☐ Crime ☐ Work ☐ Other (specify) _____

Accident date and time _____ State of Accident _____

Place of accident and county _____

Description of Accident _____

Primary Insurance

Insurance Plan Name _____

Group Name (Employer Name) _____ Group Number _____

Insurance Customer Service Phone # _____

Insurance Billing Address _____

City _____ State _____ Zip code _____

Policyholder's Name _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Patient's Relation to Policyholder _____

Secondary Insurance

(If Applicable)

Insurance Plan Name _____

Group Name (Employer Name) _____ Group Number _____

Insurance Customer Service Phone # _____

Insurance Billing Address _____

City _____ State _____ Zip code _____

Policyholder's Name _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Patient's Relation to Policyholder _____

Please note that your insurance plan may require a co-payment, co-insurance or deductible; your payment will be requested at the time of your visit.

Patient/Authorized Representative Signature _____ Date Signed _____