



Occupational Medicine/Workers' Compensation Patient Registration Form

Date: _____

PATIENT INFORMATION

Name: _____ Male Female

Date of Birth: _____ SS#: _____

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____ Cell Ph#: _____

**Confidential Phone:* _____

Home Email: _____

**Confidential Email:* _____

**For more information on the confidential phone and email, please see the attached consent form*

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Ph#: _____

Cell Ph#: _____

DESCRIPTION OF INJURY OR ILLNESS

Date of Injury or Illness: _____

Details of Injury or Illness: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Contact: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

Employer Fax: _____

Employer Email: _____

Based on government regulations, we are required to ask the following:

What is your preferred language? _____

Race

- American Indian or Alaska Native
- Black or African American Asian
- Native Hawaiian or Other Pacific Islander
- Caucasian
- I prefer not to answer

Ethnicity

- Hispanic or Latino
- Non-Hispanic or Non-Latino
- I prefer not to answer

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

Except to the extent the charges are associated with an authorized Workers' Compensation claim, I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred is due at the time of service. I also understand that the charges not covered by insurance and not associated with an authorized Workers' Compensation or Occupational Health claim remain my responsibility and I assign all insurance benefits to this office. I understand that if my account is turned over to a collection agency, payment becomes my responsibility.

Signature _____ Date _____

Signature _____ Date _____

CONSENT FOR TREATMENT

I, the undersigned consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES (ATTACHED)

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature _____ Date _____

VERIFICATION INFORMATION (for Internal Use Only)

Verified By: _____

Work Comp Visit? Yes No

Occ Med Visit: Yes No

Drug Screen Required? Yes No

Special Instructions: _____

Verified With: _____

Responsible Party: _____

Is verification prior to treatment necessary?
(See Employer Authorization) Yes No