Occupational Medicine/Workers' Compensation

Patient Registration Form

Date: test

PATIENT INFORMATION

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip: test

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#:

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

DESCRIPTION OF INJURY OR ILLNESS

Date of Injury or Illness: Time of Injury or Illness: ☐ A.M. ☐ P.M.

Details of Injury or Illness:

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