WORKERS' COMPENSATION / OCCUPATIONAL MEDICINE PATIENT REGISTRATION

Patient Information

Patient's Full Name:

Reason for Visit:

Date of Birth: Gender: □ Male □ Female

Social Security No.:

Local Address: Apt No.:

City: State: Zip:

Primary Contact No.: □ Home □ Cell □ Work

Secondary Contact No.: □ Home □ Cell □ Work

Email Address:

Permanent Address: Apt No.:

City: State: Zip:

Parent/Legal Guardian of Minor or Incapacitated Adult Only

Full Name:

Contact No: Date of Birth:

Relationship to Patient:

Employer

Employer Name:

Address: Suite No.:

City: State: Zip:

Telephone No.: Fax No.:

Supervisor Name:

Workers' Compensation Carrier

Workers' Compensation Carrier:

Policy No.: Claim No.:

Address: Suite No.:

City: State: Zip:

Telephone No.: Fax No.:

Date of Injury: **Time of Injury:**

Authorization to Treat and Bill

This authorization covers all services rendered to the above patient for today and all future dates of service. I may submit a written revocation of the authorization; however, my decision to revoke will not affect or undo any events that occurred before I notified you. I give consent for the above named patient to be treated. I authorize the release of any information necessary to process all claims as an occupational or workers' compensation claim. I understand that if my claim is denied, I will be responsible for all charges incurred for all services rendered. I also understand that my medical and claim information regarding my injury/illness/care will be shared with the insurance carrier, the industrial commission or/and my employer.

Patient/Guardian Name:

Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

This acknowledgement covers all services rendered to the above patient for today and all future dates of service. I may submit a written revocation of the authorization; however, my decision to revoke will not affect or undo any events that occurred before I notified you. We reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.

Patient/Guardian Name:

Signature **Date**

