Occupational Health Registration Form

Primary Health Medical Group

Patient Information:

Last Name: First Name: M.I.:

Mailing Address: Apt #:

City/State/Zip:

Home Phone: Cell Phone: Work Phone:

Date of Birth: Sex: Male Female Family Physician Name:

Marital Status: Social Security #:

Employer Information and Reason for Visit:

Employer Name: Employer Address: City/State/Zip:

Employer Phone: Employer Fax:

☐ Work Injury Care Date of Injury: _____ How did your injury occur?

☐ Other (describe)

☐ Drug Screen *Test Type* ☐ Non-DOT ☐ DOT ☐ Observed

☐ Breath Alcohol *If DOT* ☐ FMCSA ☐ FTA ☐ FAA ☐ FRA ☐ USCG ☐ PHMSA ☐ HHS

Reason For Test ☐ Post Accident/Injury ☐ Pre-Emp ☐ Random ☐ Reasonable Suspicion ☐ Return to Duty/Follow-Up

Additional Information:

Emergency Contact: Phone: Relationship to Patient:

Race (please select): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Decline ☐ Other ☐ Sign Language ☐ Spanish ☐ Russian ☐ Indian (including Hindi & Tamil)

Can we leave a message regarding your medical care and test results? ☐ Yes ☐ No

Email Address: **Preferred Pharmacy/Location:**

I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

This office has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not wish to share your healthcare information with other medical providers you can contact the IHDE at (208)332-7253 or www.idahohde.org.

Authorization to release to employer: By signing this form, you are hereby authorizing PHMG to release to your employer, information associated with any Occupational Health service. This may include, but is not limited to, information related to any pre-employment physical, fitness-for duty test, drug screening, or any other employer-ordered service unrelated to injury or illness. **Notwithstanding the foregoing, PHMG reserves the right to release any information to the employer without your authorization to the extent required or allowed by applicable law, including but not limited to disclosures for workers compensation, payment purposes, or other purposes identified in our Notice of Privacy Practices.**

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ **(Initials)**

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Printed Name: _____

FOR OFFICE USE ONLY **Check-In Time:**

WORKERS' COMPENSATION

W/C Surety: _____ Surety Phone: _____ Surety Fax: _____

Company Contact Name: _____ Title: _____ Phone Number: _____

Date/Time Contacted: _____ By: _____ **Secure Fax Number:** _____

Employer Screen Available for WC? ☐ Yes ☐ No (If No, send copy to OH) Notes: _____

DRUG AND ALCOHOL SCREENING - TRACKING INFORMATION

☐ Billed in eCW ☐ COC/ATF Faxed/Mailed to MRO/Employer

Staff: _____ Courier: _____ Tracking Number: _____ ☐ Pick-up Scheduled

OTHER SPECIAL SERVICES AUTHORIZED BY OH

☐ Billed in eCW ☐ Employer notified of results per employer screen

Staff: _____

Notes:

R 4/15

Code	Service	Price
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____