Occupational Health/Workers' Compensation Registration Form

Patient Information:

Last Name: | First Name: | M.I.:

Mailing Address: | Apt #:

City/State/Zip:

Home Phone: | Cell Phone: | Work Phone:

Preferred method of contact for reminder calls and other electronically generated messages:
(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number :
☐ Home ☐ Cell ☐ Work

Family Physician Name: | Date of Birth: | Sex: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other________________________________ | Social Security #:

Emergency Contact Name: | Phone: | Relationship to Patient:

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?

☐Physical ☐Other

☐ 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:

Email Address:

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

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

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

Preferred Pharmacy Name & Location

I certify that I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I am eligible for the insurance indicated on this form and 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 authorize PHMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. 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. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PHMG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on our Public Website.

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.

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

Patient/Guardian Signature: ____ **Date:** ____________________________________

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

WORKERS' COMPENSATION (FRONT OFFICE)

W/C Carrier: ______________________________ Carrier Phone: ____________________ Carrier Fax:______________________________

Company Contact Name: ____________________ Title: ___________________________ Phone Number:__________________________

Date/Time Contacted: ______________________ By:______________________________ Secure Fax Number:______________________

Notes:____

TRACKING INFORMATION (BACK OFFICE)

Staff: ____

COC/ATF: Faxed/Mailed to MRO/Employer/TPA

ePassport ID #:__________________________________

Fed Ex Tracking Number: __________________________

Pick-up Scheduled: ______________________________

Notes: ____

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Additional services NOT listed on Employer Screen

Price	CPT Code	Service
$__________	___________	________________________________
$__________	___________	________________________________
$__________	___________	________________________________
$__________	___________	________________________________

☐ All Occ Health services documented in Billing Notes

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