

Occupational Health 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)			
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:	
<input type="checkbox"/> Work Injury Care	Date of Injury: _____	How did your injury occur?
<input type="checkbox"/> Other (describe)		
<input type="checkbox"/> Drug Screen	Test Type	<input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT <input type="checkbox"/> Observed
<input type="checkbox"/> Breath Alcohol	If DOT	<input type="checkbox"/> FMCSA <input type="checkbox"/> FTA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> USCG <input type="checkbox"/> PHMSA <input type="checkbox"/> HHS
Reason For Test	<input type="checkbox"/> Post Accident/Injury <input type="checkbox"/> Pre-Emp <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty/Follow-Up	

Additional Information:

Emergency Contact:	Phone:	Relationship to Patient:
Race (please select):	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline		
Ethnicity (please select one):	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
Preferred Language (please select one):	<input type="checkbox"/> English <input type="checkbox"/> Bosnian <input type="checkbox"/> Decline <input type="checkbox"/> Other	Can we leave a message regarding your medical care and test results? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Indian (including Hindi & Tamil)		

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 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 \$15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Primary Health Medical Group is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email. **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.

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If No, send copy to OH)	Notes: _____

DRUG AND ALCOHOL SCREENING - TRACKING INFORMATION

<input type="checkbox"/> Billed in eCW	<input type="checkbox"/> COC/ATF Faxed/Mailed to MRO/Employer
Staff: _____	Courier: _____
Tracking Number: _____	<input type="checkbox"/> Pick-up Scheduled

OTHER

SPECIAL SERVICES AUTHORIZED BY OH

<input type="checkbox"/> Billed in eCW	<input type="checkbox"/> Employer notified of results per employer screen	Code	Service	Price
Staff: _____		_____	_____	\$ _____
Notes:		_____	_____	\$ _____
R 3/16		_____	_____	\$ _____