Occupational Health Registration

PATIENT INFORMATION

______________________________ ____________________ ____/____/________
Patient Name SSN# DOB MM/DD/YYYY

______________________________ ____________________ ________ __________
Address/Apt/Suite City State Zip Code

(______) ______-________ ____________________ ______________________________
Primary Phone **Preferred Pharmacy** Emergency Contact Name & #

DEMOGRAPHICS

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Gender
☐ Male ☐ Female
☐ Other__________________

Ethnicity
☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Preferred Language
____

EMPLOYER/ORGANIZATION INFORMATION

______________________________ ______________________ (______) ______-________
Employer/Organization Authorizing Visit Authorizing Contact Name Authorizing Contact Phone

________________________ (______) ______-________ ______________________________
Work Comp Insurance Insurance Adjuster Phone Case/Claim ID

REASON FOR VISIT

☐ **Pre-employment** ☐ **Random** ☐ **Post Accident** ☐ **Other:** ______________________________

☐ Drug Screen ☐ Physical ☐ TB Test ☐ BAT ☐ PFT ☐ RFT ☐ EKG

☐ Vaccine ☐ Audiogram ☐ Lab ☐ Other: _______________

☐ **Injury at work** ______________________________ ____/____/________ ____:____ ☐ AM ☐ PM
Injury Description Injury Date & Time

I hereby authorize Medac Corporate Health and Urgent Care Services, its physicians, employees and agents, together with any clinics, hospitals or laboratory designated by Medac Corporate Health and Urgent Care, to perform appropriate tests, screenings or examinations on me, relating to my employment, prospective employment, and/or program participation. Medac Corporate Health and Urgent Care and/or its medical examiner is authorized to use or disclose the above-named individuals' health information to the designated entity authorizing visit. This information may be disclosed to and used by my employer or other organization for employment or participation purposes including assessing my ability to perform essential functions. I understand that while Medac Corporate Health and Urgent Care will attempt to bill the designated guarantor for services rendered, any unpaid charges are ultimately my responsibility and will be paid in full by me if payment is not obtained.

____ ____/____/________
Patient Signature Date MM/DD/YYYY

Revised: 02/18/2020