Occupational Services Intake Form

Complete this form and return it to registration with your picture ID and all paperwork you have with you regarding your services today. Thank you.

Employee/Patient Full Legal Name: ____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ (must complete if seeking treatment for a work-related injury or illness)

Home Address: ____

City: ____________________ State: __________ Zip: _____________ Sex ______ Male _____ Female

Home/Cell Number: ____________________________ Email: __________________________________

Date of Birth: _________________ Driver's License# __________________________ Exp Date: _______

Referring company or employer name: ____

Supervisors Name and Phone Number: ____

Please check why you are here today:
☐ DOT physical ☐ Pre-employment Physical ☐ Drug Screening and/or Breath Alcohol ☐ Other __________________
☐ Work-Related Injury or Illness

If you are here for a work-related injury, please complete the injury information below. Otherwise sign the bottom of the form and return to registration. Thank you.

Date of Injury/Illness: __________________________ Time of Injury: ___________________________
Describe in detail how were you injured, where on your body is your injury or where are you experiencing pain:
____
____
Did you report your injury when it occurred: ______ Yes _____ No If yes, to whom: ______________________________

I authorize **First Choice Urgent Care**, its Physicians and associates to perform an examination and any associated treatment including x-rays, laboratory studies or any other services that are deemed necessary in regards to my services today and on any subsequent visits. I authorize the release of any medical records, or other information to my employer, insurance carrier, or any other employer agent for whom these services are being authorized**. I also authorize the disclosure of any records obtained from my care at Garden City Hospital to be released to my employer, insurance carrier, or any other employer agent for whom these services are being authorized.** I understand if services are found not authorized I may be responsible for payment of services related to this service. I give my consent and permission to **First Choice Urgent Care** to obtain a specimen to be analyzed for drug use, controlled substances, alcohol and/or misuse of prescription medication. I understand and authorize the result of this testing will be disclosed to the employer requesting the services. Disclosure and use of results, medical information or any other private information will be limited in accordance with applicable laws covering confidentiality of medical records. I understand I have the right to refuse treatment or services and the employer authorizing these services can and will be notified. The signature below acknowledges this statement and if I am requested to provide a specimen for substance testing, I understand the specimen I am providing is my own.

Signature: ____ **Today's Date:** _____________________________