WorkRight
Occupational Medical & Physical Therapy Center

PATIENT INFORMATION

Today's Date:_____ Current Time:_____
Admitted by:

FIRST NAME:_____ LAST NAME:_____MI:__ SUFFIX:__GENDER:_____

SOCIAL SECURITY#:_____ DATE OF BIRTH:_____ AGE:___ PATIENT ID:_____

ADDRESS:_____ APT#:_____

CITY: _____ STATE:_____ ZIP:_____

HOME PH: _____ CELL PH:_____ WORK PH:_____

E-MAIL PERSONAL: _____ E-MAIL WORK:_____

OCCUPATION:

NEW EMPLOYEE: ☐YES ☐ NO ☐CONTRACTOR ☐SELF EMPLOYED

Employer Name:_____ Your Position:_____

Address:_____ CITY: _____ STATE:_____ Zip:_____

Employer Contact Name:_____ E-MAIL: _____

Employer Phone# : _____ Contact CELL PH#:_____ FAX #: _____

ARE YOU EMPLOYED BY HIRE AGENCY? ☐YES ☐NO NAME OF AGENCY: ___ _____PHONE:_____ ____

WHAT IS THE REASON FOR TODAY'S VISIT? CHECK ALL THAT APPLY

☐ NEW EMPLOYEE ☐ ANNUAL ☐ RANDOM ☐ OTHER: _____

☐ PHYSICAL EXAM ☐ DOT (CDL) ☐ DRUG SCREEN ☐ BREATH ALCOHOL TEST ☐ TB TEST ☐ OTHER: _____

NOTICE OF PRIVATE PRACTICES

Your name and signature below indicate that you are aware of Health Insurance Portability and Accountability Act (HIPAA). A copy is available to you upon request. If you have any questions regarding HIPAA, you may request information of the administrator at 708-579-4900.

NAME:_____ ✘ SIGNATURE:_____DATE:_____

CONSENT & PAYMENT

The information I provided is correct to the best of my knowledge. I will not hold WorkRight , its health providers , or its employees responsible for any errors or omissions that I may have made in completing the information on this form. You may contact my employer to verify the purpose and payment of my visit. If payment is denied I am consenting to be charged the amount and obligated to pay. If I have no employer and coming on my own I consent to be charged on the form of payment I presented to Workright.

✘ SIGNATURE: _____DATE: _____

IF my visit includes drug screening and/or breath alcohol test, I hereby consent to the collection of Urine, Breath, Hair, and/or Saliva specimen(s) by WorkRight, its agents or affiliates, and testing laboratory designated by my Employer or WorkRight, for the purposes of testing for the presence of Alcohol and/or Drugs. In accordance with and subject to the terms and safeguards of the above referenced Employer's Substance Abuse Prevention Policy, I further consent and agree that the laboratory will provide the results of any tests performed on such specimens to the Employer, the Employer's designated Medical Review Officer (MRO), and where required by law, to the appropriate federal and state agencies, including the Department of Transportation (DOT).

For all others, I consent Workright to perform services that the physicians, medical professionals, and assistants find necessary such as medical, diagnostics, treatments, processes, and procedures. I understand that this care may include tests, examinations, x-rays, drawing of my blood and collection of biological fluids. I give permission on the administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); I allow medically appropriate screenings that are beneficial to my health and completion per my employer's requirements.

✘ SIGNATURE: _____DATE: _____