PREMIER URGENT CARE

Occ Med/Work Comp Registration Form

PATIENT INFORMATION

Social Security #: _____ Today's Date: _____

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMPLOYMENT

Employer: _____ Work Phone: _____

Address: _____

Name of Primary Contact Person: _____

Contact Email: _____ Fax: _____

Payor Information (Work Comp Only):

Worker's Comp Carrier _____

Billing Address _____

_____

Phone Number _____ Fax # _____

Name of Contact Person _____ Ext: _____

Claim Information (Work Comp Only):

Claim Number ** _____

Date of Injury _____

Date Injury Reported _____

****EMPLOYER AUTHORIZED TREATMENT FOR INITIAL INJURY/SERVICES: YES NO** Initials:_____

AUTHORIZATION FOR PHYSICAL EXAMINATION AND/OR TESTING

I authorize Premier Urgent Care to examine and treat me for a work-related injury or pre-employment/diagnostic evaluation and/or perform diagnostic testing which may include obtaining a specimen(s) of my urine, saliva, or blood for chemical analysis, in accordance with requests by the company with which I am employed, or with which I am seeking employment. The purpose of this is to evaluate my abilities to perform essential job functions, or to determine or exclude the presence of drugs, alcohol, or other substances, in accordance with the substance abuse policy of the employer. I understand that these tests and/or physical examination results will be released to authorized personnel only. I, therefore, consent to these tests for diagnosis, substance use, and/or physical examination for treatment and/or employment. I understand that a copy of today's findings will be released to my employer which may include drug, alcohol, mental and physical health information. I understand that decisions may be made concerning my current work status or application for employment as a result of these tests or physical examination.

_____ _____

Signature of Employee/Patient *Date*

PREMIER URGENT CARE

Accident / First Report of Injury Form

PATIENT INFORMATION

Name: _____ Sex: Male _____ Female_____

Address: _____
(Street , City , State, Zip Code)
Telephone: _____ E-Mail: _____

Date of This Report: _____ Date of Accident: _____

EMPLOYER: _____

NATURE OF INJURY

Abrasion _____	Laceration _____
Fracture _____	Aspiration _____
Poisoning _____	Puncture
Bite _____	Scalds
Bruise _____	Burn
Scratches _____	Concussion
Cut _____	Shock (el.) _____
Dislocation _____	Sprain _____

Other (specify) _____

BODY PART(S) INJURED

Abdomen	(R / L)	Ear	(R / L)
Ankle	(R / L)	Wrist	(R / L)
Back	(R / L)	Elbow	(R / L)
Arm	(R / L)	Eye	(R / L)
Chest	(R / L)	Foot	(R / L)
Face	(R / L)	Hand	(R / L)
Finger	(R / L)	Knee	(R / L)
Head/Neck	(R / L)	Leg	(R / L)
Mouth	(R / L)	Tooth	(R / L)
Nose	(R / L)	Scalp	(R / L)

DESCRIBE THE EVENTS THAT LED TO THE INJURY (ex. Fell, operating machinery, chemical exposure)

NAME THE OBJECT OR SUBSTANCE THAT DIRECTLY INJURED THE EMPLOYEE (ex. Knife, floor, acid)

SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN EVENT OCCURRED (cutting, climbing)

Patient's Signature: _____ Date: _____

Patient Receipt of HIPAA Privacy Notice

PREMIER URGENT CARE

Dear Patient,

Premier Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Premier Urgent Care provides patients with the HIPAA Privacy Notice of Privacy Rights.

While not required in order to receive treatment at Premier Urgent Care, we are obligated under the federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Premier Urgent Care may use and disclose my protected health information. I understand that Premier Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____

Printed Patient Name

Date

_____

Signature of Patient or Parent/Guardian

****

Please answer the following questions:

Which telephone number would you prefer us to use? _____
Best time to reach you_____
Would you prefer us to reach you via e-mail? ____**yes** ____**no** _____**e-mail**
Can we leave a message on you answering machine? ____**yes** ____**no**
Can we leave a message with a household member? ____**yes** ____**no**
Can we give your medical information to a household member? ____**yes** ____**no**
If yes, name of household member_____

Office Use Only: (to be completed only when patient declines to sign acknowledgement.)
_____Check here if patient declined to sign acknowledgement

Staff Signature: _____Date: _____
Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.
To be filed in patient's records