



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 Immediate Medical Care: A Network of Urgent Care facilities treating ALL of your medical needs.

**www.PremierIMC.com**



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**

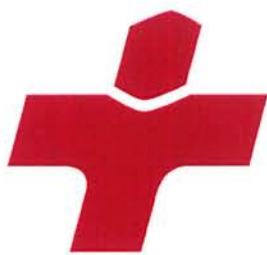
- |                   |               |
|-------------------|---------------|
| Abdomen (R / L)   | Ear (R / L)   |
| Ankle (R / L)     | Wrist (R / L) |
| Back (R / L)      | Elbow (R / L) |
| Arm (R / L)       | Eye (R / L)   |
| Chest (R / L)     | Foot (R / L)  |
| Face (R / L)      | Hand (R / L)  |
| 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: \_\_\_\_\_



# 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

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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 your 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