Comprehensive Care
Occupational Medicine Specialists

TIME IN:_____

DATE:_____

Patient Information / Consent Form

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Phone #: _____ **Cell Phone #:** _____

Date of Birth: _____ **Social Security #:**_____

Company Name: _____

Company Phone: _____

By signing below, I authorize Comprehensive Care and/or staff to collect appropriate specimens and medical information from me for a physical examination and/or drug screening. I understand this may include blood, urine, breath alcohol, hair testing, medical history and any other information deemed critical by the treating physician. I also authorize the release of this information to my current/potential employer or to the entity requiring these services while I am employed with that company. I understand that if my visit is for an injury or illness that is later deemed non work related, I will be held personally responsible for all charges incurred in diagnosis and treatment.

_____ _____
Employee Signature **Date:**

_____ _____
Authorized Representative for Employee **Title:**

Notice: By initialing, I acknowledge receipt of Notice of Privacy Practices: _____

FOR INJURIES, PLEASE COMPLETE

Date of Injury:_____ **1st Date of Treatment**_____

Was It Reported?: Yes_____ **No**_____ **To whom?:**_____

Where was treatment given:_____
(If other than Comprehensive Care)

Supervisors Name:_____ **Phone/Ext.:**_____

(rev 7/18/11)