



Occupational Health Registration

PATIENT INFORMATION

Patient Name, SSN#, DOB MM/DD/YYYY, Address/Apt/Suite, City, State, Zip Code, Primary Phone, Preferred Pharmacy, Emergency Contact Name & #

DEMOGRAPHICS

Race, Gender, Ethnicity, Preferred Language

EMPLOYER/ORGANIZATION INFORMATION

Employer/Organization Authorizing Visit, Authorizing Contact Name, Authorizing Contact Phone, Work Comp Insurance, Insurance Adjuster Phone, Case/Claim ID

REASON FOR VISIT

Pre-employment, Random, Post Accident, Other, Drug Screen, Physical, TB Test, BAT, PFT, RFT, EKG, Vaccine, Audiogram, Lab, Other, Injury at work, Injury Description, Injury Date & Time

I hereby authorize Medac Corporate Health and Urgent Care Services, its physicians, employees and agents, together with any clinics, hospitals or laboratory designated by Medac Corporate Health and Urgent Care, to perform appropriate tests, screenings or examinations on me, relating to my employment, prospective employment, and/or program participation.

Patient Signature, Date MM/DD/YYYY