

PATIENT INFORMATION:

## Occupational Medicine/Workers' Compensation Patient Registration Form

PATIENT EMPLOYMENT:

Name:	Sex: □M □F	Employe	r Name:	
Date of Birth:		Employe	r Phone:	
Social Security #:		Extr	n:	
Street Address /Apt #:		Employe	r Address:	
City, State, Zip:				
Home Phone:				
Local or Cell Phone:		Contact N	Name:	
Confidential Email Address:		Contact F	Phone:	
Based on government regulations we are rec	quired to ask the following info	ormation:	☐ I prefer not to answer	
Preferred Language:		Race:	☐ American Indian or Alaska Native	□Asian
Ethnicity: ☐ Hispanic or Latino		I	☐ Black or African American	□ Caucasian
☐ Non Hispanic or Latino		I	☐ Native Hawaiian or Other Pacific	Islander
DESCRIPTION OF INJURY OR ILLNI	ESS: To be completed by patient	t		
Date and Hour of injury:			□AM	□PM
NOTICE OF PRIVACY PRACTICES: I have reviewed the American Family Care Notice of	of Privacy Practices and understand	hat I may rec	quest a copy of the policy at any time.	
NOTICE OF PRIVACY PRACTICES:	E OF ACCOUNT: ervices rendered and I understand that insurance remain my responsibility ar of collection fees and/or attorney's fe comp claim.	at the payment and assign ins ess and all co	nt of charges incurred in this office is due urance benefits to this office. In the ever ourt costs if any. Patient may be responsi	t my account is turned ble for payments if a
I have reviewed the American Family Care Notice of ASSIGNMENT OF BENEFITS AND GUARANTEE I acknowledge full financial responsibility for any set I also understand that the charges not covered by it over to a collection agency, I agree to pay all costs workers' comp visit is not authorized as a worker's CONSENT FOR TREATMENT:  I, the undersigned, consent to the care and treatments as to the effect of such treatment.	E OF ACCOUNT: ervices rendered and I understand that insurance remain my responsibility ar of collection fees and/or attorney's fe comp claim.	at the payment and assign ins ess and all co	nt of charges incurred in this office is due urance benefits to this office. In the ever ourt costs if any. Patient may be responsi	t my account is turned ble for payments if a rantees have been made
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Name: Sex:	Employer Name:
Date of Birth:	Employer Phone:
Social Security #:	Extn:
Street Address /Apt #:	Employer Address:
City, State, Zip:	
Home Phone:	
ocal or Cell Phone:	Contact Name:
Confidential Email Address:	Contact Phone:
Based on government regulations we are required to ask the following	information: ☐ I prefer not to answer
Preferred Language:	Race: ☐ American Indian or Alaska Native ☐ Asian
Ethnicity: ☐ Hispanic or Latino	☐ Black or African American ☐ Caucasian
☐ Non Hispanic or Latino	☐ Native Hawaiian or Other Pacific Islander
DESCRIPTION OF INJURY OR ILLNESS: To be completed by pa	diand
Date and Hour of injury:	
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NOTICE OF PRIVACY PRACTICES: I have reviewed the American Family Care Notice of Privacy Practices and underst.  ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: I acknowledge full financial responsibility for any services rendered and I understan I also understand that the charges not covered by insurance remain my responsibil over to a collection agency, I agree to pay all costs of collection fees and/or attorne workers' comp visit is not authorized as a worker's comp claim.	and that I may request a copy of the policy at any time.  d that the payment of charges incurred in this office is due at the time of service ity and assign insurance benefits to this office. In the event my account is turner y's fess and all court costs if any. Patient may be responsible for payments if a
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Updated 6-24-19