american family care®
URGENT CARE

Occupational Medicine/Workers' Compensation
Patient Registration Form

PATIENT INFORMATION:

Name: _____ Sex: ❑ M ❑ F
Date of Birth: _____
Social Security #: _____
Street Address /Apt #: _____
City, State, Zip: _____
Home Phone: _____
Local or Cell Phone: _____
Confidential Email Address: _____

PATIENT EMPLOYMENT:

Employer Name: _____
Employer Phone: _____
Extn: _____
Employer Address: _____
_____
_____
Contact Name: _____
Contact Phone: _____

Based on government regulations we are required to ask the following information: ❑ *I prefer not to answer*

Preferred Language: _____

Ethnicity: ❑ Hispanic or Latino
❑ Non Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ Caucasian
❑ Native Hawaiian or Other Pacific Islander

DESCRIPTION OF INJURY OR ILLNESS: *To be completed by patient*

Date and Hour of injury: _____ Hour: _____ ❑ AM ❑ PM

Details of Accident: _____
_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICES:
I have reviewed the American Family Care Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT:
I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fess and all court costs if any. Patient may be responsible for payments if a workers' comp visit is not authorized as a worker's comp claim.

CONSENT FOR TREATMENT:
I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

Patient Signature: _____ **Date:** _____
Patient/Guardian Signature (if patient is a minor)

VERIFICATION INFORMATION: *To be completed by American Family Care front office staff*

AFC Staff Member: _____ Verified with: _____
Work Comp Visit: ❑ Yes ❑ No Responsible Party: _____
Occ Med Visit: ❑ Yes ❑ No Drug Screen Required: ❑ Yes ❑ No
Is verification prior to treatment necessary according to the employer face sheet? ❑ Yes ❑ No
Special Instructions: _____
_____
_____

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Updated 6-24-19