



OCCUPATIONAL MEDICINE
PATIENT REGISTRATION

SOCIAL SECURITY - -
FIRST NAME LAST NAME MI
STREET ADDRESS
CITY STATE ZIP
HOME PHONE ( ) - DATE OF BIRTH / /
SEX: M F MARTITAL STATUS: S M SEP D W RACE: RELIGION:
EMPLOYER
EMPLOYER ADDRESS
CITY STATE ZIP
COUNTY WORK PHONE ( ) -
WORK CONTACT or SUPERVISOR

HAVE YOU EVER BEEN HERE BEFORE? YES NO IF YES, WHEN?

SPOUSE'S FULL NAME WORK PHONE
FAMILY PHYSICIAN

EMERGENCY CONTACT NAME AND RELATIONSHIP TO PATIENT /
ADDRESS:
EMERGENCY CONTACT PHONE# ( ) -

WERE YOU TREATED IN THE EMERGENCY ROOM or SOMEWHERE ELSE FOR THIS ISSUE? YES NO
IF YES, WHEN AND WHERE DID YOU SEEK TREATMENT?

PLEASE PROVIDE US WITH THE FOLLOWING ADDITIONAL INFORMATION
PRIVATE HEALTH INSURANCE (GIVE CARD FOR COPY TO BE PLACED ON CHART)

INSURANCE CARRIER NAME
ADDRESS

PHONE# ( )
POLICY# ID#

POLICY HOLDER DOB EMPLOYER

I hereby give authorization to PMMC's Occupational Health-CarePlex to provide me with medical treatment for my work-related injury/illness and/or employment-related physical examination. I understand that employment-related physical examinations are not meant to replace routine health care as provided by my private physician. I also understand that an employment-related examination is often times not a complete evaluation and is being performed solely to evaluate my ability to safely perform the tasks required of me by the job I am applying for or am currently performing. I hereby give PMMC's Occupational Health-CarePlex authorization to release to my employer, insurance company, and their representatives any medical information which may be requested concerning my condition or treatment for this work related injury/illness, or employment-related physical examination.

PATIENT SIGNATURE DATE

WITNESS
DATE



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