Midtown Occupational Health Services

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name: Date:
Address: City, State, Zip:
Email Address: Date of Birth:
Cell phone: SSN:
Gender: Male Female Other Dominant Hand: Right Left
Interpreter requested? Yes No If yes what language?

EMPLOYMENT INFORMATION

Employer: Job Title:
Address: City, State, Zip:
Supervisor: Work Phone:
Length of employment:

TELL US ABOUT YOUR INJURY

Date of injury: City & State where injury occured:

How were you injured?

What body part hurts?

IMMUNIZATION HISTORY

When was your last tetanus shot? (Approximate Date)

Do you have any allergies? Yes No Please list:

MEDICATIONS

Are you currently taking any medications? Yes No

Please list:

HEALTH CONDITIONS *Please check all that apply:*

Diabetes

High Blood Pressure

Heart Condition

Other Major Health Conditions? *Please List:*

Are you currently being treated for any chronic medical conditions or have you had any other serious illnesses or injuries? Yes No

Please explain:

SURGICAL HISTORY

Have you had any surgical procedures? Yes No

Please explain:

SOCIAL HISTORY

Do you smoke or use smokeless tobacco?	Yes	No	How often?
Do you drink alcohol?	Yes	No	How often?
Do you use illicit drugs?	Yes	No	How often?

FAMILY MEDICAL HISTORY

Does a family member have: (Please check all that apply)

Diabetes *Relation to you:*

High Blood Pressure *Relation to you:*

Heart Condition *Relation to you:*

Other Major Health Conditions? *Please List Condition(s) and relation to you:*

WORKMAN'S COMPENSATION HISTORY

Have you had any previous workman's compensation claims? Yes No

Please explain:

Do you work with any permanent or partial restrictions? Yes No

Please explain:

PATIENT AUTHORIZATION

I understand that I am responsible for payment should treatment be determined to be NON- work related. I authorize the release of any medical information verbally and/or in writing necessary to process my workman's compensation claim and to insure the best possible coordinated medical care for me

Signature Date Witness Date

DIAGNOSIS AND TREATMENT CONSENT

I hereby authorize the physicaisn of Midtown Occupational Health Services P.C. to perform a medical history, physical examination, diagnostic testing (x-rays, EKGs, EFAs, etc), all medical treatment, physical therapy and all necessary blood, urine, or breath testing including drug/alcohol tests. This consent also includes, if needed, Independent medical exams (IMEs), fitness for duty exams, impairment rating exams, as well as functional capacity evaluations (FCEs) and work hardening therapy, if necessary. I also understand and authorize that my employer may be informed of the results.

Signature Date Witness Date