Arrival time: _____:_____
Services completed: _____:_____

1/2025

Occupational Services Injury Care Intake Form

Complete this form and return it to registration with your picture ID and all paperwork you have with you regarding your services today. Please ensure ALL FIELDS are completed. Thank you.

Full Name (First, Middle Initial, Last): _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ /_____ /_____
(must complete if seeking treatment for a work-related injury or illness)

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Number: _____ Cell Carrier: _____ Email: _____

☐ **Ensure Appointment Preferences are enabled**

Driver's License# _____ Exp Date: _____ Sex: ____ Male ____ Female

Referring company or employer name: _____ Job Site Name/ID: _____

Supervisor's Name and Phone Number: _____

Date of Injury/Illness: _____ Time of Injury: _____

Describe in detail how were you injured, where on your body is your injury or where are you experiencing pain:

_____

_____

_____

Did you report your injury when it occurred: _____ Yes _____ No If yes, to whom: _____

I authorize Occupational Care Service, its Physicians and associates to perform an examination and any associated treatment including x rays, laboratory studies or any other services that are deemed necessary in regards to my services today and on any subsequent visits. I authorize the release of any medical records, or other information to my employer, insurance carrier, or any other employer agent for whom these services are being authorized. I understand if services are found not authorized I may be responsible for payment of services related to this service. I give my consent and permission to obtain a specimen to be analyzed for drug use, controlled substances, alcohol and/or misuse of prescription medication. I understand and authorize the result of this testing to be disclosed to the employer requesting the services. Disclosure and use of results, medical information or any other private information will be limited in accordance with applicable laws covering confidentiality of medical records. I understand I have the right to refuse treatment or services and the employer authorizing these services can and will be notified. The signature below acknowledges this statement and if I am requested to provide a specimen for substance testing, I understand the specimen I am providing is my own.

Signature: _____ **Today's Date:** _____