Occupational Health/Workers' Compensation Registration Form

Patient Information:

Legal Name: Last Name First Name M.I.

Previous Name: Preferred Name:

Mailing Address: Apt # City/State/Zip:

Home Phone: Cell Phone: Preferred Method of Contact: ☐Voice Or ☐Text

Email Address: Date of Birth:

Sex Listed with Insurance: ☐ Male ☐ Female

Sex Assigned at Birth: ☐ Male ☐ Female

Gender Identity: We ask about your gender identity to tailor our care to you.
☐ Male ☐ Female ☐ Choose Not To Disclose ☐ Other: _____
☐ Transgender Male (female-to-male) ☐ Transgender Female (male-to-female) ☐ Genderqueer, neither exclusively male or female

Sexual Orientation: We ask about your sexual orientation to ensure we provide personalized and inclusive care tailored to your needs. This information is protected and helps us better understand and support your health and well-being.
☐ Straight or heterosexual ☐ Bisexual ☐ Choose Not To Disclose
☐ Lesbian, gay, or homosexual ☐ Don't Know / Unknown ☐ Other: _____

Social Security #: Family Physician or Pediatrician:

Marital Status: Preferred Language: Translator needed: ☐Yes ☐No

Emergency Contact Name & Relationship: Emergency Contact Phone #:

Preferred Pharmacy:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Race: ☐ White ☐ Hispanic ☐ Asian ☐ Decline ☐ Other: _____
☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

Employer Information:

Employer Name:

Employer Address: City/State/Zip:

Employer Phone: Employer Fax:

Reason for Visit:

☐ **Work Injury Care:** Date of Injury: _____ How did your injury occur?

☐ **Drug Screen** Check mark type(s): ☐ DOT ***DOT Test Type:*** ☐ FMCSA ☐ FTA ☐ FAA ☐ FRA ☐ USCG ☐ PHMSA ☐ HHS
☐ Non-DOT ☐ Observed

☐ **Physical** Check mark type: ☐ DOT ☐ Non-DOT ☐ Other (describe):

☐ **Other Services** Check mark type(s): ☐ Breath Alcohol Testing ☐ Immunizations / Vaccines ☐ Labs ☐ TB Testing ☐ Other (describe):

Reason For Test: ☐ Post Accident/Injury ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion ☐ Return to Duty/Follow-Up

I certify that I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. I authorize PHMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PHMG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the PHMG Public Website. We are obligated by the Idaho Patient Act to inform you that you will receive a bill for medical services from Primary Health Medical Group -10482 W. Carlton Bay Dr. Garden City, ID 83714. Phone: 208-955-6470. If you have diagnostic lab work and have Medicare, Medicare Advantage from any carrier, Medicaid, Aetna, Cigna, or United Health Care you may receive a bill from Interpath Laboratory –PO Box 1208, Pendleton, OR 97801. Phone: 866-289-4093. By signing this, you acknowledge that you were informed. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. **Authorization to release to employer: By signing this form, you are hereby authorizing PHMG to release to your employer, information associated with any occupational health services. This may include, but is not limited to, information related to any pre-employment physical, fitness-for-duty test, drug screening, or any other employer-ordered service unrelated to injury or illness.**

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ **(Initials)**

2024 **Patient/ Legal Guardian Signature:** **X** _____ **Date:**

Why am I being asked about my sexual orientation and gender identity?
Each patient has unique health needs. Lesbian, gay, bisexual, and transgender (LGBT+) individuals often have different health needs. Understanding sexual orientation and gender identity helps us provide appropriate healthcare services and culturally sensitive care to all our patients.

What is gender identity?
Gender identity is someone's inner sense of their gender. For example, a person may think of themselves as male, as female, as a combination of male and female, or as another gender.

What does transgender mean?
Transgender people have a gender identity that is not the same as their sex at birth.

- Transgender Male describes someone assigned female at birth who has a male gender identity.
- Transgender Female describes someone assigned male at birth who has a female gender identity.
- Genderqueer and non-binary describe someone who has a gender identity that is neither male nor female or is a combination of male and female.

How do I choose the correct information?
There are no right or wrong answers. If you don't find an answer that fits, you can choose "Other," or "Don't know/ Unknown," or you can talk with your provider.

Who will see this information?
Your provider(s) and other staff associated with your care will see this information, and it will become part of your medical record. Your information is confidential and protected by law, just like all your other health information.

What if I don't want to share this information?
You have the option to check the box, "Choose not to disclose." Later, your provider may ask you these questions privately during your visit. You can choose whether to share this information at that point and/or you can ask your provider more questions.

How will this information be used?
Your provider(s) will use this information to help meet your healthcare needs. In addition, gathering this information from all patients allows the health center to see if there are gaps in care or services across different populations. This helps us improve the care we give to our patients.

FOR OFFICE USE ONLY	**Check-in Time:**
Date/Time Contacted:	By:
Company Contact Name:	Title:
Company Phone Number:	Company Email:
W/C Carrier:	Carrier Phone #:
Notes:	
TRACKING INFORMATION (BACK OFFICE)	
Staff:	
COC/ATF: Faxed/Mailed to MRO/Employer/TPA	
Qpassport/ePassport ID #:	
Fed Ex Tracking Number:	
Pick-up Scheduled (write Confirmation Code):	
Notes:	

Occ Health service notes (optional)

Price	CPT Code	Service
$		
$		
$		
$		

☐ All Occ Health services documented in Billing Notes