

Occupational Health/Workers' Compensation Registration Form

Patient Information:

Last Name:		First Name:	M.I.:
Mailing Address:		Apt #:	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred method of contact for reminder calls and other electronically generated messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text		If Voice, Please Select Preferred Number : <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Family Physician Name:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____		Social Security #:	
Emergency Contact Name:	Phone:	Relationship to Patient:	

Employer Information and Reason for Visit:

Employer Name:			
Employer Address:		City/State/Zip:	
Employer Phone:		Employer Fax:	
<input type="checkbox"/> Work Injury Care: Date of Injury: _____ How did your injury occur?			
<input type="checkbox"/> Physical <input type="checkbox"/> Other (describe)			
<input type="checkbox"/> Drug Screen	Test Type:	<input type="checkbox"/> Non-DOT	<input type="checkbox"/> DOT <input type="checkbox"/> Observed
<input type="checkbox"/> Breath Alcohol	If DOT:	<input type="checkbox"/> FMCSA	<input type="checkbox"/> FTA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> USCG <input type="checkbox"/> PHMSA <input type="checkbox"/> HHS
Reason For Test:	<input type="checkbox"/> Post Accident/Injury	<input type="checkbox"/> Pre-Emp	<input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Return to Duty/Follow-Up

Additional Information:

Email Address:			
Race (please select):	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other <input type="checkbox"/> Decline
Ethnicity (please select one):	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Decline
Preferred Language (please select one):	<input type="checkbox"/> English	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Indian (including Hindi and Tamil) <input type="checkbox"/> Other

Preferred Pharmacy Name & Location

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 \$20.00 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.

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 service. 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)

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Check-in Time:

WORKERS' COMPENSATION (FRONT OFFICE)

W/C Carrier: _____	Carrier Phone: _____	Carrier Fax: _____
Company Contact Name: _____	Title: _____	Phone Number: _____
Date/Time Contacted: _____	By: _____	Secure Fax Number: _____
Notes: _____		

TRACKING INFORMATION (BACK OFFICE)

Staff: _____	<u>Additional services NOT listed on Employer Screen</u>		
COC/ATF: Faxed/Mailed to MRO/Employer/TPA	Price	CPT Code	Service
ePassport ID #: _____	\$ _____	_____	_____
Fed Ex Tracking Number: _____	\$ _____	_____	_____
Pick-up Scheduled: _____	\$ _____	_____	_____
Notes: _____	\$ _____	_____	_____

All Occ Health services documented in Billing Notes