



OCCUPATIONAL MEDICINE REGISTRATION FORM

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Revised: [09/14/2026]

PATIENT INFORMATION

Patient Name _____ DOB _____
Address _____ SS# _____
City _____ State _____ Zip Code _____
Primary Phone _____ Email _____
Preferred Pharmacy/Location _____
Occupation _____
Primary Care Provider _____
Employer/Organization Authorizing Visit _____

DEMOGRAPHICS

RACE

- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

SEX

- ☐ Male ☐ Female

ETHNICITY

- ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

PREFERRED LANGUAGE _____

INJURY AT WORK

☐ YES ☐ NO

Injury Description

Date/Time of Injury ____/____/____ AM PM

I hereby authorize Wilmington Health to perform appropriate testing, screening, or examinations on me, relating to my employment and/or program participation. Wilmington Health is authorized to use or disclose my health information gathered on this visit to the designated guarantor. I understand that this information may be disclosed to and used by the employer or other organization for employment or participation purposes including assessing my ability to perform essential functions. I understand that I may be financially responsible for any services completed without proper employer authorization.

Patient Signature _____ Date _____