OCCUPATIONAL MEDICINE REGISTRATION FORM

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PATIENT INFORMATION

Patient Name _____ DOB _____

Address _____SS# _____

City _____ State _____ Zip Code _____

Primary Phone _____ Email _____

Preferred Pharmacy/Location _____

Occupation _____

Employer_____

Primary Care Provider _____

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 _____