

PATIENT INFORMATION FORM

Sign In Date: / / Sign in time: : a.m. / p.m.

Last Name: _____ First Name: _____ M.I.: _____
Social Security #: _____ Date of Birth (MM/DD/YYYY): _____ Male
Female
Address: _____ City: _____ ST: _____ Zip: _____
Contact phone (home or cell): _____ Work phone: _____ Single
Married

****Employer information refers to the company that you are testing for****

Employer Name: _____ Location/Store Number: _____
Supervisor Name: _____ Supervisor Phone: _____
Is your employment arranged through a temporary hire agency? Yes No Name of agency: _____
Agency Phone: _____

The Reason for Today's Visit
Help us know more about what you need today.

What is the main reason for today's visit:

I was injured on the job

I am here for one of the following **non-injury** services:

- Physical exam Drug Screen Physical and Drug Screen
 DOT (CDL) certification Other: _____

If you are here for a **work-related injury**, please tell us about it.

Injury date: _____ Injury Time: _____

Where were you when the injury occurred? _____

How did the injury happen? _____

What part of your body is injured? _____

Please check which side of your body is injured.

Right Left Both

Using the figure at right, please circle the areas where you are injured.



The information provided is correct to the best of my knowledge. I will not hold Highland Clinic, APMC, its health partners, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. You may contact my employer to verify the purpose of my visit, if necessary. I consent to hospital services, treatment and diagnostic procedures by the clinic as ordered by the physician/practitioner and consultants selected by the physician. I authorize Highland Clinic, APMC to provide all or any of my medical records related to today's visit, to include my social security number for identification purposes, to my employer or entity appointed my employer, and release Highland Clinic, APMC, its physicians, nurses, technicians and any other employee from any and all liabilities, claims, or causes of action that may result from this authorization.

Signature: _____ Date: _____