Adventist Health Castle

OCCUPATIONAL MEDICINE REGISTRATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

EMPLOYEE INFORMATION

First Name:_____Last Name:_____ Suffix:_____

SSN:_____-_____-_____Home Phone:_____Cell Phone:_____

Middle Name:_____Email Address:_____

Provide your email and receive specials, health topics, & more!

Date of Birth_____/_____/_____ Sex at Birth: ❑M ❑F ❑Other Marital Status: ❑Married ❑Single

Mailing Address:_____ City/State/Zip Code:_____

Address 2:_____

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Race:_____Preferred Language:_____Hispanic/Latino: ❑ YES ❑ NO

How did you hear ❑ Drive By ❑ Insurance ❑ Doctor (Referring Physician/Hospital:_____)
hear about us? ❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet ❑ Instagram ❑ Facebook
❑ First Aid Station/Event (Please specify):_____)

Preferred Pharmacy City:_____ Preferred Pharmacy Zip Code:_____

EMERGENCY CONTACT

1. Name:_____Relationship:_____Phone Number:_____
2. Name:_____Relationship:_____Phone Number:_____

METHOD OF PAYMENT

My method of payment today will be at the responsibility of: ❑ Self-Pay ❑ Employer

REASON FOR VISIT TODAY

❑ Pre-employment ❑ Post-accident ❑ Return-to-duty ❑ Random ❑ Job Change ❑ Reasonable Cause

❑ Other:_____

EMPLOYER INFORMATION

Company Name:_____

Contact Person:_____Phone Number:_____

Employee Signature:_____Date:_____