

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

## PATIENT INFORMATION

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

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

Mailing Address: \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Hispanic/Latino:  YES  NO

**How did you hear**  Drive By  Insurance  Doctor  Employer  Friend/Family  Hotel  Facebook  Instagram  
**hear about us?**  First Aid Station/Event (Please specify): \_\_\_\_\_

**Preferred Pharmacy Location:** \_\_\_\_\_ *\*Please indicate specific location and city of preferred pharmacy.*

**Primary Care Physician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

## EMERGENCY CONTACT/NEXT OF KIN *\*Please provide the BEST contact numbers for each contact*

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## EMPLOYERS INFORMATION

Company Name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax Number: \_\_\_\_\_

## DESCRIPTION OF YOUR INJURY

**Were you injured at work?** \_\_\_ Yes \_\_\_ No **Date of Injury:** \_\_\_\_\_ **Injured Body Part:** \_\_\_\_\_

**Does your company require a drug screening?** \_\_\_ Yes \_\_\_ No *\*If you are unsure, please contact your employer to confirm*

**In a short summary, please describe what happened:**

\_\_\_\_\_  
\_\_\_\_\_

## WORKERS COMPENSATION INSURANCE CARRIER

**Are you a Federal Employee?** \_\_\_ Yes \_\_\_ No *\*If yes, please provide any additional document (i.e. CA-16 from your employer) to complete*

Company's Insurance Carrier **\*REQUIRED** \_\_\_\_\_

Adjuster's Name (If applicable): \_\_\_\_\_ Adjuster's Phone Number: \_\_\_\_\_

Claim Number (If applicable): \_\_\_\_\_

## PERSONAL INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holders SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Policy Holders SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Print Name of Patient or Guardian:** \_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_