INDUSTRIAL PATIENT INFORMATION

Please FAX immediately after injury!

Fax: 209-832-2210

PATIENT INFORMATION

PATIENT NAME_____ BIRTHDATE_____ SEX_____
(LAST) (FIRST)

HOME ADDRESS_____PHONE_____

CITY_____ STATE_____ ZIP CODE_____

SS#_____ JOB TITLE_____DESCRIPTION_____

EMPLOYER INFORMATION

EMPLOYER_____ PHONE (____) _____

ADDRESS_____ FAX (____) _____

CITY_____ STATE_____ ZIP CODE_____

DATE OF INJURY_____ PLACE OF INJURY_____ DATE LAST WORKED_____

NATURE OF INJURY_____

WORKER'S COMPENSATION INFORMATION

WORKERS COMP INSURANCE CARRIER_____

ADDRESS_____PHONE (____) _____

CITY_____ STATE_____ ZIP CODE_____

FAX (____) _____ POLICY #_____

CLAIM #_____

VISIT AUTHORIZED BY_____

DRUG SCREEN REQUESTED? YES____ NO ____ BREATH ALCOHOL TEST REQUESTED? YES_____ NO_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE ANY MEDICAL TREATMENT, ANESTTHETICS OR SURGICAL PROCEDURES AS THE ATTENDING PHYSICIAN DEEMS NECESSARY. I AUTHORIZE TRACY URGENT CARE TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT.

PATIENT SIGNATURE _____ DATE _____ WITNESS_____