PrimeCare
URGENT & FAMILY CARE

OCCUPATIONAL HEALTH - PATIENT REGISTRATION

Reason for Visit _____ **Employer Name** _____

Last Name_____ First Name_____ MI_____

Social Security #_____ Date of Birth_____ ☐ Male ☐ Female

Mailing Address_____ Apt #_____

City_____ State_____ Zip_____

Home #_____ Cell # _____ Work # _____

Primary Care Physician_____ Preferred Pharmacy _____

List of Current Medications _____

I AUTHORIZE Prime Care Family Care, Inc. to perform a medical evaluation and/or any drug/alcohol testing requested by _____. I also authorize Prime Care Family Care, Inc. to release the results of my evaluation and/or any applicable testing to the management of the company for its own use in matters relating to my employment.

I UNDERSTAND AND AGREE, PER FEDERAL LAWS, that if *I knowingly provide* false or misleading answers or withhold any medical information during any phase of this medical evaluation and/or applicable testing, the company will have sufficient grounds for terminating my employment or withdrawing any offer of employment.

I UNDERSTAND that it is my responsibility to provide the clinic with any medical records, including but not limited to treating physician names, medication and dosage, specialist reports pertaining to medical evaluation.

I UNDERSTAND that should my visit require services above and beyond the scope of the requested occupational health services, I will provide valid health insurance information or self-pay for medical services rendered.

If for any reason, my employer does not pay for the charges incurred for pre-employment services, I understand that I am responsible for payment. All overdue accounts will be sent to a collection agency. You agree to be responsible for a $40 collection fee, and all associated legal fees, such as interest and court courts, in addition to the amount owed.

PLEASE NOTE: Prime Care reserves the right to deny non-emergency services for delinquent accounts, threatening, intimidating, or abusive behavior of any kind.

I HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT SIGN- _____ Date_____

PRINT- _____