

Chart # \_\_\_\_\_



Medical/Occupational Health

### Patient History Information Form

Patient Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status: (S) (M) (D) (W)

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Permanent or Temporary Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address :( If different from above) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

*Parent or Guardian Last Name:* \_\_\_\_\_ *First Name:* \_\_\_\_\_ *MI:* \_\_\_\_\_

*SSN:* \_\_\_\_\_ *Date of Birth:* \_\_\_\_\_

**Emergency Contact Person:**

Full Name \_\_\_\_\_ Phone number: \_\_\_\_\_ Relation: \_\_\_\_\_

\*\*\*\*\*

(Without this information, we can not file a claim and you will be responsible for the bill the day of service)

\* **Primary Insurance:** \_\_\_\_\_ **Insured Name:** \_\_\_\_\_

**Date of Birth of Insured:** \_\_\_\_\_ **SS# of Insured:** \_\_\_\_\_

\* **Secondary Insurance:** \_\_\_\_\_ **Insured Name:** \_\_\_\_\_

**Date of Birth of Insured:** \_\_\_\_\_ **SS# of Insured:** \_\_\_\_\_

I agree that the above information is correct: \_\_\_\_\_

Signature

Date

**Brunswick:** 912-264-9111 • 1111 Glynco Parkway Bldg 1 Suite 10, Brunswick GA 31525

**Jesup:** 912-588-9110 • 111 Colonial Way, Jesup, GA 31545

**Pooler:** 912-330-9655 • 1215 US Highway 80 E, Suite 600, Pooler, GA 31322



## Authorization for Treatment

\* \* This form must be completed before treatment will be provided \* \*

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Company Phone #: \_\_\_\_\_ Company Fax #: \_\_\_\_\_

Company Contact: \_\_\_\_\_

Bill to: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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

Service Needed:

- Treatment for on-the-job injury
- Urine drug screen (DOT / Non-DOT) (Please circle appropriate choice)
- DOT Physical
- Non-DOT Physical

Other (please specify): \_\_\_\_\_

Medication: \_\_\_\_\_ Provide in office OR \_\_\_\_\_ Prescription

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

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