NEW CLIENT INFORMATION
SERVICES REQUESTED

Company Name: _____Todays Date: _____

Company Address: _____

_____

Phone Number: _____ Fax Number: _____

Contact Person: _____Position at Company: _____

Cell Number: _____ Email: _____

Billing Information:

Billing Address: _____

Accounts Payable Contact: _____

Worker's Comp. Information:

Worker's Comp. Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Policy Number: _____

Services Requested:

Physical Examination Type: _____

☐ Pulmonary Function Test ☐ Respirator Fit Test ☐ Audiogram ☐ Other _____

Breath Alcohol Test: ☐ DOT ☐ NON-DOT

Drug Screen: ☐ DOT ☐ NON-DOT ☐ Quick Screen ☐ Hair ☐ Other _____

Injury Treatment:

Post-Accident Drug Screen: ☐ DOT ☐ NON-DOT ☐ Quick Screen

Post-Accident Breathe Alcohol Test: ☐ DOT ☐ NON-DOT

Please Fax this information to: (225) 215-4445
Or email to: dgilbert@phcurgentcare.com, kmetrejean@phcurgentcare.com,
and mhilse@totaloccmed.com