



# Freedom Urgent Care

SETON MEDICAL CENTER HARKER HEIGHTS

## PATIENT REGISTRATION FORM OCCUPATIONAL MEDICINE

**PLEASE PRINT**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

RACE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME NUMBER: (\_\_\_\_\_) \_\_\_\_\_ CELL NUMBER: (\_\_\_\_\_) \_\_\_\_\_

Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patients' health status, treatment, or the informed decision making process such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction.

REASON FOR VISIT:       INJURY       PHYSICAL       DRUG SCREEN ONLY       OTHER

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

COMPANY NAME: \_\_\_\_\_

COMPANY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

I verify that the above information provided is true and correct to the best of my knowledge. I understand the above information is for clinic registration purposes only and that I will be required to show a picture ID at the time of collection of my drug/alcohol specimen.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient/Guardian/Accompanying Adult)