Rincon Medical Urgent Care Center- Worker's Compensation

Patient Information Sheet

Today's Date_____/_____/_____

Patient Name _____ DOB_____/_____/_____

Employer Name_____ Job Title_____Active Employment_____

Date of Injury/Accident ____/_____/_____ Describe Injury/Accident _____

_____

Pain Scale (1=mild - 10=Extreme) _____

When was your last Tetanus Shot _____

What Medications are you currently taking?

Medicine Name	Dosage	Frequency

Are you Allergic to any Medications?_____ If Yes, Please List _____

Medical/ Surgical History, include any previous injuries (both work and non-work related) _____

_____

_____

Family Medical History _____

_____

Tobacco Use: ☐ No ☐ Yes If yes, how much daily_____

Alcohol Use: ☐ No ☐ Yes If yes, how much daily_____

Drug Use: ☐ No ☐ Yes If yes, what and how much daily_____

Female: When was your last normal period?_____/_____/_____

Patient/ Responsible Party Signature_____ **Date**_____/_____/_____

Physician Signature_____ Date_____/_____/_____

Rincon Medical Urgent Care Center-Worker's Compensation

Please Print

Date: _____/_____/_____

Patient's Name: _____
(First) (Middle) (Last)

Social Security Number: _____-_____-_____ **Gender:** ☐ Male ☐Female **DOB:**_____/_____/_____ **Age:**_____

Patient Address: _____

City:_____ **State:**_____ **Zip**_____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Work Phone** (_____)_____

Please complete if the patient is under the age of 18

Parent/ Guardian Name _____
(First) (Middle) (Last)

Patient address if different from above: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone (_____)_____ **Cell Phone** (____)_____ **Work Phone** (_____)_____

Employer Name_____

Employer Address_____

City _____ **State:**_____ **Zip:**_____

Worker's Compensation Contact:_____

Contact's Phone (____)_____Fax(_____)_____

The signature below serves as authorization for medical treatment by the physician, physician assistant or nurse. It also provides authorization to **Rincon Medical Center** to furnish and/or release any information necessary to insurance carrier, third party administration, and or health benefit payor representatives in order to process health care claims. This authorization also serves as permission to release my medical records to my designated primary care physician's office to ensure continuity of care. I understand that I may withdraw this authorization to release medical information at any time, when I communicate in writing. I acknowledge that **Rincon Medical Center** will file the insurance as a courtesy, but it is my responsibility to understand the insurance coverage. I understand that I am financially responsible for balances not covered by the worker's compensation insurance carrier.

Patient/Responsible Party Signature_____ **Date:**_____/_____/_____