



## Patient Registration/Information

Name:		Social Security Number:	
Address:		Zip Code:	
Home Phone #:	Cell Phone #:	Date of Birth:	
Company Name (Who does your paycheck come from?)		Occupation:	
Company Address or Location:		Company Phone #:	
Email Address:			
Type of Service you are here for: <input type="checkbox"/> Drug Screen <input type="checkbox"/> Breath Alcohol Test <input type="checkbox"/> Injury (please complete section II) <input type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-placement Physical <input type="checkbox"/> Random <input type="checkbox"/> DOT Physical <input type="checkbox"/> Post Accident <input type="checkbox"/> Other: _____ <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Return to Duty/Follow-up			

### **II. If you are here for an on the job injury please complete the following information**

Is this the:

First report of Injury  
 I have had an injury to the same body part before (either work or non-work related)

Report of Aggravation (Claim # \_\_\_\_\_)

Change of Attending Physician (Claim # \_\_\_\_\_)

Date/Time injury occurred:

Describe accident (specify injured body part):

### **Personal Health Insurance Information (PHI) *\*\*only complete for injury related care\*\****

In the event that your worker's compensation claim is denied and you have exhausted the appeals process, we will gladly bill your personal health insurance for the charges that have been incurred. Please review the financial policy on the consent form for additional information regarding how this information is used.

I do not have PHI

I do have PHI-please complete the lines below and give your card to the receptionist to make a copy.

I do have PHI, but do not want to provide COMPI with this information at this time.

Personal Insurance Plan Name:

Policy Number:

Group Number: