OCCUPATIONAL MEDICINE CLINIC

12000 Richmond Avenue Ste 180
HOUSTON, TX 77082
281-855-1700
www.occmedicineclinic.com

CLINIC REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)		DATE:
Name: Last	First	MI
Date of Birth:		Age:
Gender: □ Male □ Female	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated	
Race or Ethnicity: □ American Indian or Alaskan Native □ Asian □ Black or African-American □ Hispanic or Latino □ Native Hawaiian or Pacific Islander □ White □ Other		
Home Address:		
City:	State:	Zip Code:
Home Phone: ( )	Cell Phone: ( )	
Employer:	Occupation:	
Employer Address:		

IN CASE OF EMERGENCY	
Emergency Contact:	Relationship to Patient:
Emergency Contact Home Number: ( )	Emergency Contact Cell Phone Number: ( )

I hereby authorize the Occupational Medicine Clinic to render service or treatment as necessary. I understand payment for services is expected at the time of service. I authorize payment of benefits to the Occupational Medicine Clinic for services rendered to myself. I understand that I am financially responsible for all charges whether or not paid by insurance and/or employer. I also authorize the Occupational Medicine Clinic or insurance company to release any information required to process my claims.

_____

Signature Date