OCCUPATIONAL MEDICINE CLINIC

16125 CAIRNWAY DR. SUITE 106
HOUSTON, TX 77084
281-855-1700
www.occmedicineclinic.com

CLINIC REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)		DATE:
Name: Last	First	MI
Date of Birth:	Age:	Social Security Number:
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

OCCUPATIONAL MEDICINE CLINIC

16125 Cairnway Dr. Suite 106 Houston, TX 77084 Phone: (281) 855-1700 Fax: (281) 855-1707
www.occmedicineclinic.com

CONSENT FORM

I give the Occupational Medicine Clinic consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review the Occupational Medicine Clinic's Notice of Privacy Practices for a more completed description of uses and disclosures before signing this consent.

I understand that the Occupational Medicine Clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic, 16125 Cairnway Dr. Suite 106, Houston, TX 77084 or website: www.occmedicineclinic.com.

I understand that I have to request a restriction of how my protected information is used. However, I also understand that the Occupational Medicine Clinic is not required to agree to the request. If the Occupational Medicine Clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

A photocopy or fax of this consent is as valid as this original.

Signature_____ Date_____
Patient, Parent or Legal Guardian

If signed by patient representative, state relationship to patient _____