

## OCCUPATIONAL MEDICINE REGISTRATION FORM

Office Use Only:	(CSR initial)
*My initial signifies that	the information on this
form has been	uploaded into the EMR.

EMPLOYEE INFORMA	ATION						
First Name:		Last Name:					
SSN: <u>-</u> -	Home Phone:		Ce	ell Phone:			
Middle Name:		Email Address:					
Date of Birth/_			•	•	health topics, & more! ⊒Married □Single		
Mailing Address:			City/St	ate/Zip Code:			
Address 2:				D	" D.M."		
What is your preferred							
					nic/Latino: 🗖 YES 🗖 NO		
	nployer	y 📮 Hotel	☐ Inter	net 🚨 Instag	gram 🚨 Facebook		
Preferred Pharmacy Cit	ty:	Preferred Pharmacy Zip Code:					
<b>EMERGENCY CONTA</b>	CT						
				Phone Numbe	er:		
2. Name:		_Relationship:	Phone Number:				
METHOD OF PAY	MENT						
My method of paymen	nt today will be at the re	esponsibility of:	☐ Self-Pay	☐ Employer			
REASON FOR VIS	IT TODAY						
☐ Pre-employment	☐ Post-accident ☐	Return-to-duty	☐ Random	☐ Job Change	☐ Reasonable Cause		
☐ Other:							
<b>EMPLOYER INFORM</b>	IATION						
Company Name:							
Contact Person:	Person:Phone Number:						
providers, or its employ I understand that ar be contacted b responsibilities shou	rmation provided is correct rees responsible for any erro ny results pertaining to servi by URGENT CARE HAWAII's b ild my employer/future emp uture employer. I understand	rs or omissions that I r ces paid by my employ illing department, acti loyer forfeit to pay for	may have made in yer/future employ ing on behalf of Ui these services. Al y employee that I i	completing the inform er may be requested. gent Care Hawaii rega ny payment issues are must pay for these sen	nation on this form. I understand that I may arding any financial directly between myself		
Employee Signature:		Date:					