TrustCareHealth™

Occupational Medicine Intake

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

DOB ____ /____ /____ Marital Status ☐S ☐M ☐D ☐W SSN _____ Gender ☐M ☐F

Address _____ Apt# ____ City _____ State _____ Zip _____

Phone (Cell) _____ (Work) _____ (Home) _____

Email _____ Employer _____

EMERGENCY CONTACT

Last Name _____ First Name _____ Relationship _____

Phone (Cell) _____ (Work) _____ (Home) _____

CONSENT FOR TREATMENT

I consent to medical evaluation and/or treatment provided to me by the staff of TrustCare Health.

I authorize TrustCare Health to disclose to my employer and/or its designated insurance carrier any information concerning my condition, including the history and physical, all laboratory reports and all X-ray reports.

I hereby release TrustCare Health and its employees from any liability arising from such disclosure.

X _____ Date _____ / _____ / _____

(Signature of patient or patient guardian if minor)

Internal Use Only

Service Requested _____

Employer Authorization _____ Date _____ TC Staff_____

Contact Name _____ Phone _____

Contact Email _____ Fax _____

Please circle if authorization was given via PHONE EMAIL FAX Time _____

How do they want the results sent? _____