Concentra®

Improve the health of America's workforce, one patient at a time.

Employer Services Patient Information

Reason for Today's Visit

❒ Injury Care ❒Physical exam ❒ DOT (CDL) Certification ❒ Drug Screen ❒ Other:______________________________

About You

Social Security # or Military DBN:______________________________ Date of birth (MM/DD/YYYY):______________

Last name: ______________________________ First name: ______________________________ M.I.:_____

Address: ______________________________ Apt. #:______ City: ______________ ST: ______ ZIP: ____________

Home phone: ______________________________ Work phone: ______________________________

Cell phone: ______________________________ ❒ Male ❒ Female ❒ Single ❒ Married

Email address:______________________________Concentra may send a detailed email: ❒ Yes❒ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

About Your Employer

Employer Requesting Services

Company name: ______________________________ Location/store number: ______________________________

Address: ______________________________ Ste. #:______ City: ______________ ST: ______ ZIP: ____________

Is your employment arranged through a temporary hire agency? ❒ No ❒ Yes

Name of agency: ______________________________ Agency phone: ______________________________

Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy Office at 800-819-5571 or privacyoffice@concentra.com.

Name: (please print) ______________________________ Date Notice Received: ______________

Signature:______________________________ Date: ______________________________

Consent (Do not complete if presenting for DOT drug/alcohol testing ONLY)

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature:______________________________ Date: ______________________________

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases.

Signature:______________________________Date:______________________________