 Worker’s Comp Registration

Patient Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Male □Female

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternate Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Cell □Work

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Lake Oconee Primary & Urgent Care reserves? □Been Here Before

□Drive-By □Internet □Mailer □Around Town □Newspaper □Neighbor

□Family/Friend □Physician Referral □Employer □Yellow Pages □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury or Illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brief Description\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has your employer been notified of this accident/injury? □YES □NO If YES; when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has a claim been filed for this incident □YES □NO If YES; what is the claim number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employment Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_ Company Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

**Medical Consent** - I hereby consent, for myself or dependent, to diagnostic and/or therapeutic medical treatment, procedures and medical imaging as deemed necessary by the provider. I acknowledge that no guarantee can be made regarding the result of any procedure performed or any medical treatment provided.

**Medical Release Authorization** - I understand that it may become necessary to release my protected health information to another entity for treatment, follow-up, continuation of care, quality assurance, collection purposes and when required by law. Such entities may include but are not limited to primary care and consulting physicians, specialists, hospitalists, employers, insurance companies and collection agencies.

**Certification** - I certify that any information I have provided is true and correct to the best of my ability. I further understand that knowingly providing false demographic and/or insurance information constitutes fraud on behalf of the responsible party.

**HIPAA** - I acknowledge receipt of the Notice of Privacy Rights with detailed information about Lake Oconee Primary & Urgent Care reserves may use and disclose my protected health information. I understand that Lake Oconee Primary & Urgent Care reserves the right to change the privacy notice and that a copy of the notice will be made available to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guarantor Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date