MED CENTER
INDUSTRIAL REGISTRATION FORM

❑ **Company Exam** ❑ **Work Related Injury**

Patient Information:

Last Name	First	MI	M/F	Birthdate: SS#:
Home address:	City	State/Zip		Home Phone:
Employer:				Work Phone:
Employer address:	City	State/Zip		Supervisor:
Insurance Carrier:	Address:			Policy #:

WORK RELATED INJURY/ILLNESS, PLEASE COMPLETE THE FOLLOWING:

Date of Injury :_____ Time of Injury:_____

Date last worked:_____ Occupation (specify job title):_____

Where did accident occur?:_____
Address

Explain what happened:_____

_____

Injury reported to employer: ❑ Yes ❑ No To whom?:_____

Emergency Information:

Emergency Contact:	Relationship:	Phone #
Alternate Contact:	Relationship:	Phone #

Consent for Treatment and Financial Agreement:
I hereby consent and authorize the administration of all procedures at MED CENTER including, but not limited to examination, x-rays, anesthetic, medical or surgical treatment. I hereby authorize MED CENTER to furnish my insurance carrier/s with any requested information from my medical records. I also authorize MED CENTER to furnish my employer/prospective employer with a result of any physical examination pertaining to my employment. ***I understand that in the event of an investigation or denial of my workers compensation claim, I am financially responsible for all services.***

_____/_____/_____
Signature Date Med Center Witness Signature

Notice of Privacy Practices Received
Sign _____
Date _____

Patient Health History **Med Center Medical Clinic**

PATIENT INFORMATION		
Name:	**Date of Birth:**	*Use other side of page if you need more room in any section.*

Preferred Pharmacy:	**Pharmacy Phone Number:**	**Pharmacy Address (include zip code):**

ALLERGIES TO MEDICATIONS	
MEDICATION	**REACTION**

CURRENT MEDICATION REGIMEN			
MEDICATION	**DOSAGE**	**FREQUENCY**	**CONDITION / SPECIAL NOTES**

PERSONAL MEDICAL HISTORY

☑	Check All That Apply to YOU	Explanation/Comments
	Heart Disease	
	Asthma/Lung Disease	
	High Blood Pressure	
	Diabetes	
	High Cholesterol	
	Thyroid Problem	
	Kidney Disease	
	Cancer	
	Genetic Disorder	
	Depression/Anxiety/Mental Disorder	
	Other:	
	Past Surgeries (Please list):	

Family Health History

Please indicate the current status of your IMMEDIATE FAMILY MEMBERS. Indicate which family member (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Condition	Family Member(s)	Status (Living, Deceased, Currently being treated)
Cancer		
Heart Disease		
Depression/Suicide		
Genetic Disorders		
Diabetes		
High Cholesterol		
High Blood Pressure		
Stroke		
Bleeding/ Clotting Disorder		
Asthma/COPD		
Other:		

SOCIAL HISTORY

Tobacco Use

Cigarettes: ☐ Never ☐ Quit Date_____

☐ Current Smoker: Packs per Day _____ # of Years _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Home Life

☐ Single ☐ Partnered/Married ☐ Divorced

☐ Widowed ☐ Other _____

Who lives at home with you?_____

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes # of Drinks per Week _____

Caffeine Intake

☐ None ☐ Coffee/Tea/Soda _____ cups per day

Drug Use

Do you use any recreational drugs? ☐ No ☐ Yes

If Yes, what type(s)?_____

Other

What type of work do you do? _____

Is there anything else we should know about?

MED CENTER MEDICAL CLINIC

6651 MADISON AVENUE
CARMICHAEL, CA 95608

TELEPHONE (916) 965-1111
FAX (916) 965-5143

CANCELLATION AND NO-SHOW POLICY

This notice is to inform you of Med Center's *Cancellation and No-show Policy*.

If you do not show up for your scheduled appointment AND if you did not cancel your appointment at least 48 hours (two full days) in advance, Med Center Medical Clinic will charge you a $50 no-show fee. The no-show fee is a separate charge that will not be covered by your insurance plan. You will be responsible for this fee in which the charges will need to be paid in full before we will schedule any further appointments.

The amount of the fee will depend on the nature of your scheduled visit. Missed follow-up appointments and cancellations less than 48 hours prior to your visit will result in Med Center implementing the $50 fee. For missed procedures, tests, special appointments, or double-booked appointments will result in a fee of $100 or more.

BEFORE CHARGING YOU A NO-SHOW FEE, MED CENTER MEDICAL CLINIC WILL CONSIDER EXTENUATING CIRCUMSTANCES ON A CASE-BY-CASE BASIS.

Why do we charge a no-show fee? Any missed appointments that are not cancelled in advance (48 hours) affects staff's time and amount of care in which we could offer to other patients who are in need. Each no-show visit represents a missed opportunity for another Med Center patient to see a provider. In addition, certain supplies and medications that we have ordered for your appointment may be at a loss if you do not attend your visit.

By signing, you are fully aware and understand Med Center Medical Clinic's no-show policy. Failure to comply will result in the implementation of the fees explained above.

Patient's Name (PRINT): _____

Patient's Signature/Guardian: _____

Date: _____

Quest Diagnostics®

Dear Patient,

All or part of your clinical laboratory testing will be performed by Quest Diagnostics. The main office is located at 6511 Golden Gate Drive, Dublin, California 94568. Quest Diagnostics will bill you for the laboratory tests ordered today. Should you carry insurance, they will, as a courtesy, send a claim to your insurance if you provide the information today on this sheet. Please note that if the laboratory receives insufficient information with which to submit a claim to your insurance, they will bill you directly. You will be responsible for the cost of today's laboratory tests. If you do not carry insurance, Quest Diagnostics, will send you a bill 5-10 days after the test results are received. They expect payment by you within 20 days after receipt of the statement. Should you have any questions about your bill, please contact them directly Monday-Friday 9:00am-5:00pm at 1-800-326-4756.

<u>All patients please complete this section:</u>

Patient Name: _____

Mailing Address: _____

Street City Zip Code

<u>Insured patients please complete this section if you wish your insurance billed:</u>

Insured/ Employee Name: _____

Relationship to Patient: _____

Insured's Employer Name: _____

Insurance Company Name: _____

Address of Insurance Company Claim Department _____

Subscriber ID# _____ Group # _____ Policy # _____

I hereby authorize payment directly to Quest Diagnostics of medical benefits otherwise payable to me. I understand that I am financially responsible for the fees not covered by this authorization.

_____ _____

Signature Date