www.workercareclinic.com

Patient Registration

Name _____

Date of Birth _____

Work Phone _____

Email _____

Cell Phone _____

How Did You Hear About Us?

☐ ER ☐ Urgent Care ☐ Primary Care ☐ Employer

☐ Friend/Family ☐ Attorney ☐ Internet Search

☐ Sign/advertisement ☐ Previous Patient

☐ Drug screen/physical exam/other service

☐ Other_____

Please complete if NOT filling out Report of Accident or Reopening Application today.

Claim # _____

Soc Sec # _____

Address _____

City _____ State _____ Zip _____

Employer of Injury_____

Occupation _____

Home Phone _____

❑ Married ❑ Single ❑ Separated

❑ Divorced ❑ Widowed ❑ Domestic Partner

Name of Husband/Wife/Partner _____

In Case of Emergency Contact

Name _____ Relationship _____ Phone _____

Local Personal Physician _____

Please read before signing:
I understand that I am financially responsible for all charges including, but not limited to, deductibles and services not covered by my insurance, regardless of coverage, and I agree to pay such charges. My signature below permits the release of all information necessary to secure payment of benefits from my insurance carrier. I understand that all laboratory, x-ray, and other testing performed by outside facilities and specialists will be billed directly to the patient by these facilities and specialists.

AUTHORIZATION: I hereby authorize the Doctor(s) and the medical staff of Yakima Care Worker to provide such medical services as may be determined to be in the best interest of the patient listed above.

I hereby authorize any holder of medical information about me to release any information needed to process my claim. I also authorize any insurance benefits to be made to Yakima Worker Care.

Our Notice Of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below, I acknowledge receipt of the Notice Of Privacy Practices.

_____ _____

Signature of Patient or Legally Auth. Date