PATIENT REGISTRATION OCCUPATIONAL/MEDICAL EXAM

PATIENTS MUST PROVIDE PHOTO ID FOR ALL SERVICES

Complete all parts of each section (both sides of the page). Your signature and the signature of a witness (person witnessing your signature) are required. PLEASE PRINT ALL INFORMATION.

NAME: ____
(LAST) (FIRST) (MI) (MAIDEN)

HOME ADDRESS: ____
(STREET) (APT. #)

____
(CITY) (STATE) (ZIP)

DATE OF BIRTH: ______________________ **SEX:** ____ **M** ____ **F**

HOME PHONE: ______________________ **SS#**______________

COMPANY NAME: ____

COMPANY ADDRESS: ____
(STREET) (SUITE/PO BOX)

____
(CITY) (STATE) (ZIP)

COMPANY PHONE: __________________________

COMPANY FAX: __________________________

OCCUPATION: ____

IN CASE OF EMERGENCY, CONTACT:______________________________
(LAST) (FIRST)

RELATIONSHIP:______________________

HOME PHONE: ________________ **WORK PHONE:** ______________

ADDRESS: ____
(STREET) (APT. #)

____
(CITY) (STATE) (ZIP)

CONSENT TO EXAMINATION

I, ______________________________________ agree to participate in a medical evaluation conducted by The OMS, Ltd. (Occupational Medicine Specialists). I understand that the medical evaluation may include questionnaires, laboratory studies, diagnostic testing and medical examinations by physicians as well as a drug testing. I also understand that these examinations are not complete physicals, that they are strictly limited to the protocol, and that they are not a substitute for my regular medical care.

I understand that participation in any or all of these examinations will be voluntary, that all information obtained will be considered strictly confidential, and that the results will be sent only to me and other designated parties that I request.

If work-related conditions are found, or any work restrictions are recommended, I understand that both my employer and I will be notified, and that examination and test findings relating to work-related conditions/recommended restrictions will be released to ____________________________.

______________________	__________________________________
(DATE)	(Signature of Employee)
______________________	__________________________________
(DATE)	(Signature of Witness)

RELEASE OF INFORMATION

I specifically authorize The OMS, Ltd to disclose to ____________________________ information from my health care record. I understand that the specific type of information to be disclosed includes: Examination and test results and that this disclosure is being made for the following purpose(s): Occupational medical surveillance program. I also understand that this authorization applies to any future examination and test results of medical evaluations performed for the purpose of this occupational medical surveillance program as well as any medical records that I authorize to be released to The OMS, Ltd.

I understand that, upon submitting a release of confidential medical information, I (or a person authorized by me) may:

Inspect my health care records at the offices of OMS during regular business hours, upon reasonable notice;

Receive a copy of my health care records or have copies of my health care records referred to another health care provider of my choice upon payment of reasonable costs;

Receive a copy of my x-ray reports or have copies of my x-rays referred to another health care provider of my choice upon payment of reasonable costs.

______________________	__________________________________
(DATE)	(Signature of Employee)
______________________	__________________________________
(DATE)	(Signature of Witness)
	__________________________________
	Printed Name of Witness)

Send completed form to: The OMS, Ltd. (Occupational Medicine Specialists)
300 West Adams, Suite 835, Chicago, IL 60606
Chicago, Illinois 60606 – Attn: Medical Services