

Occupational Medicine Clinic Client Information

Date: _____

1. Company Information

Completed by: _____

Company Name: _____ No. Employees: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Pager: _____

Type of Business: _____ Cell: _____

2. Contact Information

1. Name: _____ email: _____

Title: _____ Phone: _____ Fax: _____

2. Name: _____ email: _____

Title: _____ Phone: _____ Fax: _____

3. Billing Information

A) Injuries: Workers' Compensation Claims to: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Title: _____ Phone #: _____

B) Physicals/Drug Screens/Immunizations (non-injury) - (complete only if different)

Type: (DOT, BAT, Collection-Only, etc...) _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Protocol: Yes No Phone #: _____

C) Other Services: (Wellness Programs, Health Fair, etc...) _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Protocol: Yes No Phone #: _____

