RIVERSIDE URGENT CARE

PATIENT REGISTRATION FORM
OCCUPATIONAL MEDICINE

PLEASE PRINT

NAME: _____**DATE:** _____

DATE OF BIRTH: _____**SSN:** _____

RACE:_____ **AGE:** _____**SEX:** _____

MAILING ADDRESS: _____

CITY:_____ **STATE:** _____ **ZIP:** _____

HOME NUMBER: (_____) _____ **CELL NUMBER:** (_____) _____

Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patients' health status, treatment, or the informed decision making process such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction.

REASON FOR VISIT: □ **INJURY** □ **PHYSICAL** □ **DRUG SCREEN ONLY** □ **OTHER**

_____

_____

_____

COMPANY NAME: _____

COMPANY PHONE NUMBER: (_____) _____**SUPERVISOR:** _____

DATE OF INJURY: _____

I verify that the above information provided is true and correct to the best of my knowledge. I understand the above information is for clinic registration purposes only and that I will be required to show a picture ID at the time of collection of my drug/alcohol specimen.

Signature: _____**Date:** _____
(Patient/Guardian/Accompanying Adult)