



**NEW CLIENT INFORMATION  
SERVICES REQUESTED**

Company Name: \_\_\_\_\_ Todays Date: \_\_\_\_\_

Company Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Position at Company: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Billing Information:**

Billing Address: \_\_\_\_\_

Accounts Payable Contact: \_\_\_\_\_

**Worker's Comp. Information:**

Worker's Comp. Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Services Requested:**

Physical Examination Type: \_\_\_\_\_

Pulmonary Function Test     Respirator Fit Test     Audiogram     Other \_\_\_\_\_

Breath Alcohol Test:     DOT     NON-DOT

Drug Screen:     DOT     NON-DOT     Quick Screen     Hair     Other \_\_\_\_\_

**Injury Treatment:**

Post-Accident Drug Screen:     DOT     NON-DOT     Quick Screen

Post-Accident Breathe Alcohol Test:     DOT     NON-DOT

Please Fax this information to: (225) 215-4445  
Or email to: [dgilbert@phcurgentcare.com](mailto:dgilbert@phcurgentcare.com), [kmetrejean@phcurgentcare.com](mailto:kmetrejean@phcurgentcare.com),  
and [mhilse@totalocmed.com](mailto:mhilse@totalocmed.com)