Family First

Eatontown office email: INFO-EATONTOWN@FAMILYFIRST-URGENTCARE.COM
Oakhurst office email: INFO@FAMILYFIRST-URGENTCARE.COM
Toms River office email: INFOTR@FAMILYFIRST-URGENTCARE.COM

WORKER'S COMPENSATION/OCCUPATIONAL MEDICINE

PATIENT INFORMATION

Patient Legal Name: First Middle Initial Last			**Date of Birth:** / /
Patient Preferred Name:		**Social Security #:** - -	
Date of Injury: / /	**Job Title:**		
Mailing Address:			**APT#:**
City:	**State:**		**Zip Code:**
Home Phone #: ( ) -	**Cell Phone #:** ( ) -	**Work Phone #:** ( ) -	
Sex: (CIRCLE ANSWER) Male Female Other (Please specify) _____	**Marital Status:** (CIRCLE ANSWER) Single Married Partnered Divorced Widowed		
Pharmacy Name & Address:			
Emergency Contact Name:	**Emergency Contact Phone #:** ( ) -	**Relationship to Patient:**	

EMPLOYER/RESPONSIBLE PARTY INFORMATION

Company Name:	**Company Address:**
Supervisor Name:	**Supervisor Phone #:** ( ) -
Insurance Company Name:	**Insurance Company Address:**
Case Manager Name:	**Case Manager Phone #:** ( ) -
Claim #: (for Worker's comp ONLY)	

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Thank you for choosing us as your healthcare provider. Family First Urgent Care is committed to maintaining integrity of your protected health information and complies with all applicable state and federal regulations. Please review the Notice of Privacy Practices that is available to you upon request or located on our website www.familyfirst-urgentcare.com, and complete this form as an acknowledgement of receipt.

By signing this document,

I understand that if I wish to receive any information regarding my Worker's Compensation/Occ Med chart of mine with Family First Urgent Care, I must contact my employer, whom is the responsible party.
_____ ***(initials)***

I understand that in order to obtain said information I may be required by my employer and/or Family First Urgent Care to sign a health disclosure form. _____ ***(initials)***

I understand that any information regarding my Worker's Compensation/Occ Med chart or any Worker's Compensation/Occ Med related appointments of mine with Family First Urgent Care will not be available to me through an online patient portal.
_____ ***(initials)***

I give permission for Family First Urgent Care to disclose any relevant protected health information of mine to my employer. _____ ***(initials)***

PLEASE CHECK ALL THAT APPLY

I would like to be contacted in the following manner:

Home Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Cellular Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Written Communication

- ☐ OK to mail to my home address

I grant Family First Urgent Care permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

- ☐ [Check here if you **DO NOT** consent for external prescription history]

_____	_____	____/____/____
Patient Name Printed	**Patient Signature**	**Date**

PERSONAL MEDICAL HISTORY

Patient Name: _____ Patient Date of Birth: ____/____/____

Please to the best of your ability fill out the sections below. If not applicable to you, write "N/A" or "none".

CURRENT MEDICATIONS (prescription and over the counter)	**DOSAGE**	**FREQUENCY**

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

ALLERGIES	**REACTION** (hives, anaphylaxis, etc.)
PAST SURGERIES/HOSPITALIZATIONS	**DATE**

Please list any ***additional medical diagnoses*** that you have that are not mentioned above:

_____

Smoking History (Please circle): Nonsmoker/Former/Current (including vaping or marijuana use)

****FOR WORKERS COMP PLEASE INITIAL BELOW AND FILL OUT PAGE 4***

Worker's Compensation and Motor Vehicle Claims · The patient must provide at time of service: *a claim number, name of Insurance carrier and phone number, date of injury and name of employer (WC)*. Without this information the patient may be held responsible for all charges, and payment will be collected at time of service.

_____ (initials)

INJURY INFORMATION

Please to the best of your ability fill out the sections below. If not applicable to you, write "N/A" or "none".

Was the incident reported to your employer? (Please Circle) Yes or No

What part of your body is injured? _____

Which side of your body is injured? (Please Circle) Right Left Both

Please rate your current pain level on the following scale (Please Circle):

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Pain)

In your own words, please describe the incident:

_____

_____

_____

_____

Using the figure below, please circle where you are injured.