# CADUCEUS

## OCCUPATIONAL MEDICINE

*Done Right.*

**FACESHEET - ALL SECTIONS ARE REQUIRED TO COMPLETE.**

Today's Date: _____

Time In: _____

Reason For Visit: (Mark as many as apply.)

☐ Physical ☐ Drug Screen ☐ Work Related Injury ☐ Follow-Up Visit ☐ Self-Pay ☐ Primary Care

**DEMOGRAPHIC INFORMATION**

☐ Male ☐ Female

Name (Print): _____

Date of Birth: _____

Social Security Number: _____

Driver's License Number: _____

Address: _____

City, State, Zip: _____

Cell/Home Phone: _____

Email Address: _____

Allergies: _____

Medications: _____

**COMPANY**

Company Name: _____

Company Dept/Job Site: _____

Supervisor/Contact Person: _____

Supervisor Phone: _____

**INJURY DETAILS**

If you were injured, please complete the below.

Date of Injury (if applicable): _____

Claim Number: _____

Body Part(s) Injured (specify left or right): _____

Describe how you were injured: _____

**READ AND SIGN**

Authorization and Permission to Treat/HIPAA Release

The information provided is correct to the best of my knowledge. I authorize CADUCEUS to provide any required medical services for me; and to release the medical information to all parties related to my care.

Signature Required: _____ Today's Date: _____

**RETURN TO FRONT DESK ONCE FILLED IN COMPLETELY.**