ROPER ST. FRANCIS PHYSICIAN PARTNERS

Occupational Medicine
Phone (843) 402-5053 Fax (843) 402-5054

Information Record

Employee Name: First		**MI**	**Last**
Home Address: Street			**City**
State/Zip	**Home Phone**	**Work Phone**	**Email Address**
Age		**Date of Birth / /**	**Social Security Number**
Job Title			
Company Name			**Hire Date**

General Information

Reason for this visit	**Did you have an accident?**	**If injury occurred on the job:**
❑ Pre-Placement Health Assessment	❑ Yes	❑ Not Applicable
❑ Injury	❑ No	❑ Date of injury: _____
❑ Fit for Duty Evaluation	❑ Not Applicable	❑ How you were injured:
❑ DOT Physical		_____
❑ Other _____		_____

Medical Information

Are you currently under a physician's care for any medical problems?

❑ No
❑ Yes: Please specify _____

Do you have allergies to drugs or to food?

❑ No
❑ Yes: Please specify _____

Personal Medical Provider:

Name _____ Phone Number _____

Emergency Contact:

Name _____Relationship _____Phone Number _____

I hereby voluntarily request, authorize and consent to medical care, diagnostic procedures and medical treatments as deemed appropriate by and delivered by RSFHC medical providers, related to the health problem(s) for which I have sought the services of RSFHC. I further consent to have all relevant results and records of these diagnostic procedures and treatment forwarded to RSFHC. I further authorize RSFHC to obtain my medical records, x-ray reports, physical therapy reports, laboratory reports, or other health related information deemed necessary to allow the RSFHC medical provider to appropriately diagnose and/or treat my medical condition(s) and/or assess my ability to work. I further authorize RSFHC to release information contained in my RSFHC Medical record necessary for review for Workers Compensation directly to RSFHC and assign to them insurance benefits otherwise payable to me.

I hold harmless RSFHC and its medical care providers from any liability regarding the release of information to RSFHC, the Insurance Company for said company, the cost containment company for said company or carrier, or any other party as required by law. A photocopy or facsimile copy of this release is effective as an original document.

Employee Signature_____ Date ____/____/_____