YOUR DOC'S IN PATIENT REGISTRATION FORM (OH & WC)

Date: ___________________ Have you been here before? ◯ Yes ◯ No

How may we help you today? ◯ DOT Physical ◯ Pre-employment Physical ◯ Pre-op Surgical Assessment

◯ Other:_______________ ◯ Employment Drug Screen (choose one) ◯ Non-DOT ◯ DOT

Is today's visit, a result of a: ◯ Motor Vehicle Accident ◯ Work Injury ◯ None

If yes, date of accident:____

If you are paying for the drug screen yourself, should a copy of the report go to your employer? ◯Yes ◯No

If yes, please provide the name of your employer:_______________________________________

Birth Date: ____/___/______ Sex: ◯ Male ◯ Female Social Security #: ______-____-______

Name: (Last)___________________________(First)_____________________________(Middle)_________________(Suffix)______

Maiden Name:(if applicable)__________________ Confidential E-mail:_______________________________________

Mailing Address:___________________________________Apt#______ City:_________________ State/Zip: ____________

Home Phone: (____) _____-_________ Cell Phone: (____) _____-_________ Work Phone: (____) _____-_________

Which is your preferred phone?: ◯ Home ◯ Cell ◯ Work May we leave a voicemail if you do not answer? ◯ Yes ◯ No

Primary Care Physician(PCP):___________________________________ Phone#: (____) _____-_________

PCP Office Location:________________________________ Fax#: (____) _____-_________

Primary Insurance:_______________________________ Social Security(if different than patient): ______-______-______

Name of Policyholder(if different than patient):____________________________________ Sex: ◯ Male ◯ Female

Emergency Contact: ____ Relationship to Patient:_______________________

Home Phone: (____) _____-_________ Cell Phone: (____) _____-_________ Work Phone: (____) _____-_________

Confidential Communication of Personal Health Information: [Please indicate individual, aside from yourself, if any, authorized to speak with staff from Your Doc's In regarding the patients' evaluation, diagnosis, treatment and billing.]

Name:____ Relationship:_____________________________Initials:__________

Employer Name and Location: ____

Employer Contact:_____________________________________ Employer Contact #: (____) _____-_________

Worker's Comp Carrier(if work accident):____________________________________ Claim #: ___________________

WC Adjustor: ____ Adjustor Phone #: (____) _____-_________

How did you hear about us? ◯ Website ◯ Family ◯ Friend ◯ PCP ◯ Employer ◯ Commercial

If you are here for a service related to your employment and your employer is paying for the service, a copy of the results will be sent to your employer. Also, it may be necessary for us to speak with your employer about the test results for any services being provided. Completion of this form indicates your understanding and permission for this to occur.

PATIENTS BEING SEEN FOR A DOT PHYSICAL

Please note that based on the results of your examination or the tests performed for your DOT physical, it may be necessary to perform additional testing to determine if you qualify for your DOT card. We will advise you of the need to perform additional tests prior to them being performed. We require payment of any additional test(s) to be collected prior to the test(s) being performed.

Preferred Language: ◯ English ◯ Spanish ◯ Other:_______________

Race:(check all that apply): ◯ American Indian ◯ Asian ◯ Black/African American ◯ Native Hawaiin/Pacific Islander ◯ White ◯ Declined

Ethnicitiy: ◯ Hispanic or Latino ◯ Non-Hispanic or Latino ◯ Declined

FOR OFFICE USE ONLY

	DUE	PAID	(Circle method)	
Bay Area	$__________	$__________	CA CC CK#	__________
Current Balance	$__________	$__________	CA CC CK#	__________
Copay	$__________	$__________	CA CC CK#	__________
Self Pay Deposit	$ 150	$__________	CA CC CK#	__________

YDI STAFF INITIALS_______________