MERCY OCCUPATIONAL HEALTH

PATIENT INFORMATION

DATE		
LEGAL NAME	SEX	HOME PHONE
ADDRESS	DOB	CELL PHONE
CITY	RACE	SSN
STATE	ZIP	MARITAL STATUS
PRIMARY DOCTOR:		

EMPLOYER INFORMATION

COMPANY THAT SENT YOU HERE	
OCCUPATION	STATUS Full-Time or Part-Time

EMERGENCY CONTACT

NAME	SEX	HOME PHONE
ADDRESS	DOB	CELL PHONE
CITY		WORK PHONE
STATE	ZIP	RELATIONSHIP
EMPLOYER:		

ATTESTATION

📖 I certify that I have accurately completed this form to the best of my knowledge. **INITIAL** _____

HIPAA POLICY

📖 I acknowledge that I have received or been offered a copy of the Mercy Services HIPAA Privacy Policy. **INITIAL** _____

AUTHORIZATION TO RELEASE

📖 I hereby authorize my physician and/or Mercy Occupational Health to release any information and/or records acquired during the course of examination and/or testing to my employer or their designated representative for the purpose of employment and/or payment processing. **INITIAL** _____

FINANCIAL POLICY

📖 I hereby authorize payment, for charges incurred for services rendered by Mercy Occupational Health, directly to the physician and/or Mercy Occupational Health. I realize any non-covered services will be my responsibility. **INITIAL** _____

PATIENT SIGNATURE: _____ **DATE:** _____