

TREMONT MEDICAL CENTER P.A.

8312 CREEDMOOR RD
RALEIGH, NC 27613
FAX: 919-870-6635

WORKER'S COMP/DRUG SCREEN REGISTRATION

PATIENT INFORMATION

NAME: _____
LAST FIRST MI

SSN: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____
CITY STATE ZIP

HOME PHONE: _____ CELL PHONE: _____

DESCRIPTION OF INJURY

BRIEF DESCRIPTION OF HOW AND WHERE THE INJURY OCCURRED:

DATE OF INJURY: _____ HAVE YOU FILED YOUR FIRST REPORT OF INJURY WITH YOUR EMPLOYER? YES NO

***FAILURE TO REPORT THIS ACCIDENT AND FILE THE PROPER FORMS MAY RESULT IN THE DENIAL OF THIS WORKER'S COMPENSATION CLAIM**

* I AUTHORIZE TREMONT MEDICAL CENTER TO PERFORM APPROPRIATE MEDICAL PROCEDURES AS DEEMED NECESSARY. I AUTHORIZE TREMONT MEDICAL CENTER TO RELEASE ANY MEDICAL INFORMATION NECESSARY -TO INCLUDE URINE DRUG SCREEN AND BLOOD ALCOHOL RESULTS- TO EXPEDITE MY INSURANCE CLAIMS.

*I ALSO UNDERSTAND TREMONT MEDICAL CENTER SERVES AS AN ALTERNATIVE TO THE HOSPITAL EMERGENCY DEPARTMENT PROVIDING ROUTINE MEDICAL CARE AND MINOR EMERGENCY TREATMENT, THEREFORE I MAY BE REFERRED BEFORE ALL SURGICAL OR MEDICAL CONDITIONS ARE KNOWN OR TREATED.

*IF AUTHORIZATION FROM MY EMPLOYER IS NOT RECEIVED, THEN PAYMENT IN FULL WILL BE MADE AT THE TIME OF SERVICE TO INCLUDE ALL FOLLOW UP CARE.

SIGNATURE OF PATIENT: _____ DATE: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____ COMPANY CONTACT: _____

COMPANY ADDRESS: _____

COMPANY PHONE: _____ COMPANY FAX: _____

TREATMENT AUTHORIZED BY: _____ POSITION: _____

HOW SHOULD WE BILL THIS VISIT? WORKER'S COMP INSURANCE OR BILL COMPANY IS A DRUG SCREEN REQUIRED? YES NO

INSURANCE COMPANY: _____ PHONE: _____ FAX: _____

CLAIMS MAILING ADDRESS: _____

ADJUSTER/CASE WORKER NAME: _____ CLAIM NUMBER: _____

HAVE YOU FILED YOUR FIRST REPORT OF INJURY (FORM 19)? YES NO