CENTRAL MEDICAL SERVICES OF SOUTHERN NEW MEXICO **EMPLOYER REGISTRATION FORM**

FIRST NAME: _____ **MIDDLE**: _____ **LAST NAME**: _____

Date of Birth: _____ **Sex**: M F **Marital Status**: ☐Single ☐Married ☐Divorced ☐ Widowed ☐Separ.

Social Security No. _____

Street Address: _____ **Apt/Suite**: _____

City: _____ State: _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone**: _____

Email: _____

PLEASE PRINT THE COMPANY NAME REQUESTING SERVICES

Company Name: _____ **Phone**: _____

Address: _____ **Authorize By**: _____

What is the main reason for today's visit: _____

I was injured on the job: ☐ Yes ☐ No **Injury Date** _____

What part of body is injured? _____ ☐ **Right Side** ☐ **Left Side**

I am here for the following *non- injury services*:

☐ Physical Exam ☐ Drug Screen ☐ DOT (CDL) Physical ☐ TB Skin Test ☐ Vaccine ☐ Other: _____

EMERGENCY CONTACT DETAILS

Name: _____ **Home Phone:** _____

Cell Phone: _____ **Relation to Patient:** _____

The information provide is correct to the best of my knowledge. I will not hold Central Medical Services, its health providers, or its employees responsible for any errors or omission that I may have made in completing the information on this form. You may contact my employer to verify the purpose of my visit, if necessary.

I hereby authorize my information to be released to my Employer/Worker's Compensation adjuster. I understand that Central Medical Services may condition treatment on my behalf of this authorization form except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. For example, CMS may have a contract with a third part (e.g. employer, imaging center) to provide fitness for duty exams. CMS may refuse to conduct the exam if you do not sign this authorization to permit CMS to release the applicable results of the exam to the employer.

I hereby acknowledge that I have been presented with a copy of Central Medical Services Notice of Privacy Practices.

_____ _____

Patient or Guardian Signature Date

FOR OFFICE USE ONLY:

Self-Pay: ☐ CC/Trans#_____ ☐ Cash ☐ Check#_____