PATIENT INFORMATION SHEET

(Please Print)

Date:_______/_______/_______

Last Name:_________________ First Name:_________________ Middle Initial:____

Social Security #_______/_____/_______ Date of Birth:_______/_______/_______

Gender: (Circle one) Male Female Non-Binary Other_______________

Phone: (_____)__________

Current Mailing Address:____

City:______________________________ State:__________ Zip:______________

Company:_________________________ Supervisor:________________________

Have you ever used Midwest Occupational Medicine before: (Circle one) Yes No

If so when? (Year)__________

Which Location? (Circle) Wood River Belleville

I, the undersigned, do hereby authorize the release of any and all information including by means of oral discussions obtained as part of this medical evaluation and treatment including medical information provided by any third parties. I hereby consent and give permission to Midwest Occupational Medicine to perform examinations, testing, and treatment and to release/discuss results and provide information of the same by reports an oral communication to the above named company, and its insurer including its authorized representative. I am willing that a copy of this authorization be accepted with the same authority as the original.

Patient Signature:_________________________ Witness:_________________________

Wood River
325 Madison (Hwy 143)
Wood River, IL 62095
Ph: 618-251-5202
Fax: 618-251-5118

IMPORTANT: Please fully complete your form, save the file to your computer, and email your completed form to greeves@midwestoccmed.com and tjurcich@midwestoccmed.com.