MIDWEST OCCUPATIONAL MEDICINE LTD

PATIENT INFORMATION SHEET

(Please Print)

Date:_____/_____/_____

Last Name:Place Text Here_____ First Name:Place Text Here_____ Middle Initial:____

Last 4 of Social Security #_____ Date of Birth:_____/_____/_____

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

Phone: (_____)_____

Current Mailing Address:Place Text Here_____

City:Place Text Here_____ State:Place Text Here_____ Zip:Place Text Here_____

Company:Place Text Here_____ Supervisor:Place Text Here_____

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 the emails listed at the top of midwestoccmed.com/forms.