Company Care Registration Form

Patient Information	
Name	
Mailing Address	
Alternate/Local Address	
Phone Number	
Cell Phone Number	
Email Address	
Date of Birth	
Patient Sex	
Marital Status	
Age	
Social Security Number	
Emergency Name	
Emergency Phone	
Race:	American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander Black or African American White Other Race Unreported/Refused to Report
Ethnicity (Cultural Background)	Hispanic or Latino Non-Hispanic or Latino Refused to Report

Employer Information	
Name of Employer	
Employer Address	
Employer Phone Number	

Workers' Comp Information	
Insurance Company	
Contact Person/Claims Adjuster	
Address	
Phone Number	
Claim Number	
Health Insurance	
Primary Insurance Name	
Primary Claim Address	
Primary Phone Number	
Primary Policyholder	
Primary Subscriber Number	
Primary Group Number	
Secondary Insurance Name	
Secondary Subscriber Number	
Secondary Group Number	

General Consent for Care and Treatment Consent

***TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________________________
Signature of Patient or Personal Representative **Date**

______________________________ ______________________________
Printed Name of Patient or Personal Representative **Relationship to Patient**

______________________________ ______________________________
Printed Name of Witness Employee Job Title

______________________________ ______________________________
Signature of Witness **Date**

Company Care
Medication List

Orange Park MEDICAL CENTER
Company Care

Patient Name:	
Patient Date of Birth:	

Name of Medication	Dosage	Frequency	Date and Time Medication Last Taken