CLINIC PHYSICAL INFORMATION SHEET

PLEASE PRINT CLEARLY

ANSWER **ALL** QUESTIONS

Last Name:____________________________________ Home Phone: ____________________________________

First Name:_______________________ M.I.__________ Work Phone:____________________________________

Street Address:______________________________________ Date of Birth:___________/__________/__________________

City:____ Social Security:____________/_________/___________

Zip Code:___________ State:_________________ Sex: Male Female Age:___________

Employer: ____

Reason for Visit: ____

Please carefully read, sign, and date the following statements:

Consent for Treatment: I recognize the need for care and hereby consent to medical or surgical procedures, topical anesthesia, x-rays, examination, tests, therapy, and/or medications acquired in the course of my examination or treatment for the illness/injury identified to my employer, the Ohio Bureau of Workers' Compensation and/or third Party payers as deemed appropriate. I understand the nature and purpose of the test and/or procedures have been Explained to me, as well as the risks and possible side effects that may accompany them. If I should refuse recommended Treatment or leave without consent of my attending Physician, I release attending Physician and all others connected with my care from any responsibility for my action. All information is confidential, but may be included in statistical reports which do not identify me, or may be released to those identified on the release of information authorization.

Release: I hereby authorize the release of the results to my employer. I have read, understood and voluntarily signed this agreement.

Signature:____ Date:____

I have received Kettering Workers' Care Notice of Privacy Practices

Signature______________________________________

Date ______/______/_______