

PATIENT REGISTRATION

(Please print clearly and complete this form in full)

PERSONAL INFORMATION		
Name:		
Social Security #	-	-
Address:		
City	State	Zip
Date of Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Home Phone: ()		
Cell Phone: ()		

COMPANY INFORMATION
Company Name:
Company Contact Name:
Contact Phone Number: ()

<p><i><u>Right to Informed Consent for Treatment:</u> I understand that I have the right to be informed of the nature and purpose of all services provided to me at Minnesota Occupational Health including the alternatives, risks, and consequences or complications of such services.</i></p> <p>Initial: _____ Date: _____</p>	<p><i><u>Release of Information:</u> I authorize Minnesota Occupational Health to disclose and furnish copies of any information relating to my care at Minnesota Occupational Health (including any information related to substance use and/or other sensitive issues) to anyone involved in payment of services, continuing care (i.e. referrals), employer and agencies who monitor/evaluate care.</i></p> <p>Initial: _____ Date: _____</p>
<p><i>I have read and understand the two statements I have initialed above.</i></p>	
Signature: _____	