Concentra®

Improve the health of America's workforce, one patient at a time.

Consumer Health Patient Information

Reason for visit: _____

Last Name:_____First Name:_____MI: _____

Date of Birth (MM/DD/YYYY): _____ ☐ Female ☐ Male

Patient SS#: _____ ☐ Married ☐ Single

Military DBN (DoD Benefits Number): _____

Patient Address:_____ Apt #:_____City:_____State:_____Zip: _____

Home Phone:_____Cell phone: _____

Patient Email Address: _____

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

Concentra may leave detailed voice messages about your visit or future appointments unless you object by checking the "No" box. ☐ No Contact Phone (best number): _____

Employer Name: City of Baytown, TX Employer Address: 2401 Market St.

Guarantor Information: If the guarantor (person financially responsible) is anyone other than the patient, complete this section.

Last Name:_____First Name:_____MI: _____

Address:_____Apt #:_____City:_____State:_____Zip: _____

DOB:_____Guarantor SS#: _____

Phone:_____

Relationship to patient: (Check one) ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Subscriber Information: If the insurance subscriber (person carrying the insurance) is anyone other than the patient, complete this section.

Last Name:_____First Name:_____MI: _____

DOB:_____Phone: _____

Address:_____Apt #:_____City:_____State:_____Zip: _____

Relationship to patient: (Check one) ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Emergency Contact Name:_____ Emergency Contact Phone: _____

Concentra's external survey partner may contact you to participate in a satisfaction survey about this visit. We rely on your feedback to help us improve the patient experience. May we contact you for a brief survey? ☐ Yes ☐ No

Consent for Medical Treatment

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (*e.g.*: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); and (c) completion of medically appropriate tests for communicable and other diseases.

✍ **Signature:** _____ Date: _____

Consent for Wellness and Preventative Health Screening

I give permission to Concentra to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening. In performing the wellness screening, Concentra does not assume any responsibility for ongoing treatment or management of care.

✍ **Signature:** _____ Date: _____

Primary Care Physician

Name: _____ City: _____

State: _____ Telephone Number: _____

Notice of Privacy Practices

Your name and signature below indicate that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy office at 800-819-5571 or privacyoffice@Concentra.com.

Name: (please print) _____ Date Notice Received: _____

✍ **Signature:** _____

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Employer Services
Patient Information

Reason for Today's Visit

☐ Injury Care ☐ Physical exam ☐ DOT (CDL) Certification ☐ Drug Screen ☐ Other: _____

About You

Social Security # or Military DBN: _____ Date of birth (MM/DD/YYYY): _____

Last name: _____ First name: _____ M.I.: ____

Address: _____ Apt. #: _____ City: _____ ST: _____ ZIP: _____

Home phone: _____ Work phone: _____

Cell phone: _____ ☐ Male ☐ Female ☐ Single ☐ Married

Email address: _____ Concentra may send a detailed email: ☐ Yes ☐ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

About Your Employer

Employer Requesting Services

Company name: City of Baytown, TX Location/store number: N/A

Address: 2401 Market St. Ste. #: _____ City: Baytown ST: TX ZIP: 77520

Is your employment arranged through a temporary hire agency? ☒ No ☐ Yes

Name of agency: N/A Agency phone: N/A

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Name: (please print) _____ Date Notice Received: _____

Signature: _____ Date: _____

Consent (If you are here for a Department of Transportation drug screen or breath alcohol test ONLY, skip this section. For all other services, please complete.)

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: _____ Date: _____

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Signature: _____ Date: _____

