Occupational HEALTH
A Lexington Medical Center Physician Practice

3799 12th Street Extension
Suite 110, Cayce, SC 29033
(803) 755-3337
FAX: (803) 955-2225

PATIENT INFORMATION

Date: _____ Social Security Number: ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Patient Name: (Last):_____ (First):_____ (MI):_____

Address:_____ Apt./Lot:_____ City:_____

County:_____ State:_____ ZIP:_____

Date of Birth:_____ Age:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Female ☐ Male

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____ Pager: ( ) _____

Employer Name: (Last): _____

Address:_____ City:_____ State:_____ ZIP:_____

Employer Contact Name: _____ Employer Contact Phone Number: ( ) _____

Authorization for Treatment: The undersigned hereby applies for outpatient services to Lexington Medical Center Occupational Health, and gives permission to the provider in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of the patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination at Occupational Health.

Release of Information: I hereby authorize the verbal and written release of all medical information pertaining to my work related injury/illness to my employer, insurance company and any medical provider involved in the diagnosis or treatment of this injury. In addition, I authorize Lexington Medical Center Occupational Health permission to obtain all necessary medical records from other healthcare facilities as deemed necessary to diagnose or treat this work-related injury/illness.

Infectious Disease Consent: I consent to appropriate tests for the presence of infection, such as, but not limited to, infection by the Hepatitis B virus or the human immunodeficiency virus. If deemed necessary for the protection of others, and I authorize the withdrawal of other body fluids for this purpose.

Assignment of Insurance/Liability Benefits: I authorize and direct the named insurers to pay directly to Lexington Medical Center Occupational Health any or all benefits up to the amount of my bill pertaining to all charges incurred. I authorize and direct the named insurers to pay directly to the provider(s) any medical and surgical benefits otherwise payable to me.

Drug Screening Requirement: I recognize that I must present a valid photo ID and a body fluid specimen that meets the standard approved temperature criteria as set forth by the Department of Transportation. I acknowledge that Lexington Medical Center Occupational Health has the right to refuse collection of unacceptable specimens.

Emergency Contact :_____ **Phone Number: (_____)** _____

I hereby authorize the release of any medical information to (1) an insurance company, workers compensation carrier, Third Party Administrator through which I claim benefits and (2) any provider involved in my medical care. I realize the authorization allows Lexington Medical Center Occupational Health to release any information to any of my insurers or providers as requested by any such insurer or provider.

I understand that I am financially responsible to Lexington Medical Center Occupational Health for all self-requested services.

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Responsible Party Signature (if different)