MARTINEZ URGENT CARE

210 OAK STREET
MARTINEZ, GA 30907
OFFICE: 706-855-1755
FACSIMILE: 706-863-2587
FAMILY PRACTICE & OCCUPATIONAL MEDICINE

EMPLOYEE DEMOGRAPHICS

NAME: ______________________________________DATE OF BIRTH: _____________SSN:___________________

ADDRESS: _______________________________________ CITY: ________________STATE:______ZIP:__________

PHONE: ___________________PLACE OF EMPLOYMENT: ____

COMPANY ADDRESS: ____ CITY: _______________________

STATE: _____ZIP__________ PHONE: ______________________________ FAX: _______________________________

IMMEDIATE SUPERVISOR: ____________________________________ NUMBER: ___________________________

Who authorized today's visit? ____

INJURY DETAILS

DATE: ___________ TIME: __________ LOCATION (WHERE IT TOOK PLACE): ____________________________

HOW DID THE INJURY OCCUR? ____

____

____

____

____

DID ANYONE WITNESS THE INJURY? ☐ NO. ☐ YES. NAME OF WITNESS: ____________________________

EMPLOYEE HEALTH HISTORY

Prior medical conditions that may be related to the injury: ____

____

Prior medical conditions that may have caused current injury: _______________________________________

____

List of any surgeries near injury site: ____

Current Medications: ____

____

Medication Allergies: ____

Known Allergies: ____

NOTICE:

If your injury is found not to be work related, and payment for medical treatment is denied by your employer, you will be held liable for any charges accrued. According to Workers Compensation Laws and Statues, we are required to comply with request from your employer and workers compensation insurer regarding your current medical records that are associated with your claim, including drug screen results.

I, ____________________________, have read over and completed this entire form to the best of my knowledge.

SIGNATURE ____ **DATE** ______________________