



Alliance Occupational Health

A member of the Central Connecticut Health Alliance

Sign-in Time _____

Date of Service _____

Patient Information

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Age _____

Driver's License State _____ DL# _____ Class _____ Other ID _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Gender: Male Female

Marital Status: Single Married

Private Patient Pay (If this box has been checked, please DO NOT complete the Employer Information section.)

Employer Information

Do you work for a Temporary Agency? Yes No

If yes, what is the agency's name? _____

Company Name _____

Company Address _____ Phone _____

Location/Store# _____ Supervisor _____

Purpose of Visit

Injury on the job? Yes No

Date of accident _____ At what time _____

Where were you injured when the accident occurred (specific location within company)?

Area of body injured _____

Right _____ Left _____

How did the accident occur?

Non-Injury purposes: Yes No

- Reason:
- Pre-Placement
 - Annual/Biannual
 - HazMat/Environmental
 - Random
 - Post Accident
 - Other _____

- Service:
- Physical
 - DOT Physical
 - Drug Screen Only
 - Physical and Drug Screen
 - Other _____

You may contact my employer to verify the purpose of my visit if necessary.

signature