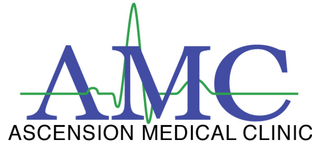


ASCENSION MEDICAL CLINIC
*Occupational and Preventive Medicine*

**214 S. Burnside Ave., Suite A • Gonzales, LA 70737 • phone: 225-647-6636 • fax: 225-647-3849**

# PATIENT DATA SHEET

Patient's Name: ______________________________ Age: __________ Birth date: ______________

Social Security #: ______________________________ Sex: □ Male □ Female

Hm Phone #: ________________ Wk Phone #: ________________ Cell Phone #: ________________

Street Address: ______________________________ Email: ______________________

City: ______________________ State: ________________ Zip Code: ________________

Employer Name: ______________________________ Occupation: ______________________

Company Contact Name: ______________________________ Contact Phone #: ________________

Is this visit for a work-related injury? □ Yes □ No Have you been here before? □ Yes □ No

Date of injury: ________________ Time of Injury: ________________ Last day worked: ________________

Explain how injury happened: ____________________________________________________

____________________________________________________________________________

**PATIENT AUTHORIZATION:**
I authorize Ascension Medical Clinic to release medical information that may be necessary to request claim reimbursement from insurance companies to whom a claim may be submitted. I also allow release of all medical information pertaining to occupational medicine (i.e. physical exams, surveillance histories and examinations, EKG's, pulmonary function tests, audiograms, work related illness and injury data, drug and alcohol test results, etc.) to the company/responsible party indicated above. This authorization will be in effect for the duration of my employment with the above noted employer plus thirty (30) years. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the federal privacy regulations. I understand that I may revoke this authorization by notifying Ascension Medical Clinic in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Ascension Medical Clinic in reliance on it before I revoke it. I understand that Ascension Medical Clinic may not condition treatment of me on whether or not I sign this authorization. I understand that refusal to sign this authorization may affect my eligibility for employment benefits.

______________________________ __________ ______________________________
Signature of Patient Date Witness (if patient is under 18)

**EMPLOYER AUTHORIZATION FOR TREATMENT:** By signing this form, I certify that I am authorized to act on behalf of the Employer and authorize evaluation and payment of medical bills for this visit.

______________________________ ______________________________
Print Name Signature

* * * * * * Office Use Only * * * * * *

__________
AMC EE Initial

**VERBAL AUTHORIZATION FOR TREATMENT:** If an authorized person is unavailable for a signature, Ascension Medical Clinic must call and get an authorization over the phone or by facsimile.

______________________________ __________ __________ __________
Name of Authorized Person of Employer Date Time AMC EE Initial

**CONTINUE TO BACK OF PAGE**