UNIVERSITY OF IOWA HEALTH CARE
Occupational Health

PATIENT REGISTRATION FORM

Legal Name (First, MI, Last)		Date of Birth	
Address	City	State/Zip	Email Address
Primary Phone	Preferred Language		Sex

Race		Driver's License Number
☐ American Indian or Alaska Native ☐ African American ☐ Asian ☐ Caucasian	☐ Hispanic ☐ Other ☐ Decline to specify ☐ Unknown	Employer

ACKNOWLEDGMENT FOR NOTICE OF PRIVACY PRACTICES

Initials: Date:

☐ I certify that I have received or been offered a copy of the UI Occupational Health HIPAA Privacy Policy.

INJURY OR ILLNESS TREATMENT – Notice of Informed Consent

Initials: Date:

☐ I hereby authorize the healthcare providers of UI Occupational Health, to perform the services requested by my employer or authorizing entity. This applies to all visits relating to the condition and terms of the employers request.

PHYSICALS AND SCREENING EXAMS

Initials: Date:

☐ I understand that I am undergoing a medical examination, medical screening, and/or evaluation at my request, or the request of an employer or prospective employer. I understand that a partial or complete physical examination may be performed, and I may be asked to undergo other tests and x-rays. I understand the examination and/or screening is not intended for treatment purposes nor to cause harm, pain or discomfort to me, and that I should not engage in any physical activities beyond that which I can physically tolerate. I understand that it is my responsibility to make the examining medical professional aware of any physical limitations. I understand that the examining medical professional is not my personal physician, and I do not expect to be treated for any ailments, and I acknowledge that no doctor-patient relationship exists between the examining medical professional and me. I hereby consent to the performance of this examination and/or screening.

Our relationship with you is limited to a one-time examination. We will not treat you or prescribe treatment to you. If we find something abnormal, we will notify either you and/or your personal physician. Completion of this examination does not certify that you are in good health. This examination does not take the place of a complete physical. We recommend that you visit your personal physician regularly for your personal health needs.

ATTESTATION

Initials: Date:

☐ I certify that I have accurately completed this form to the best of my knowledge.

PATIENT SIGNATURE		Date:
SIGNITURE OF LEGAL GUARDIAN		Date:
SIGNTAURE OF PERSON WHO COMPLETED FORM ON BEHALF OF PATIENT		Date: