IA REGISTRATION

Patient Information

Print Patient's
Full Name_____
Last First Middle

Street_____

City_____State_____
Zip Code

Date of Birth_____ Age_____ Sex_____ Home Phone_____

Social Security #_____

Driver's License #_____

Treatment Authorization

Date_____

Reason for Visit: ☐ Drug Screen ☐ Breath Alcohol ☐ Blood Alcohol ☐ PE ☐ Other

Authorized by_____Phone_____

Company Name_____

Consent to Treatment

I consent to any medical examination rendered the patient under the general or special instructions of the physician. I certify that no guarantee or assurance has been made to me as to the results which may be obtained. I authorize the release of the results of this examination and test results to the employer that authorized them.

Signature _____Date_____

Computer Acct #_____