



Treatment Authorization and Information Sheet

Patient Information

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home/Cell: _____ Work: _____
E-mail Address: _____
Social Security #: _____ - _____ - _____ Single Married Male Female
Occupation: _____ Part Time Full Time
Have you ever been here before? Yes No If so, what year? _____
Why are you here? Work related Injury Date of Injury: _____
 Physical Exam Drug Screen TB Skin Test
 Other (What reason? _____)
Who sent you? Yourself Your employer Your new employer

Employer Information

Company Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Person Authorizing Treatment: _____
Company Insurance Carrier Name: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Policy# _____ Effective Date: _____

Consent for Treatment and/or release of information to your insurance or employer:

I hereby give my consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician on duty. I give my consent for treatment to any physician or staff member at Industrial Medical Group of Santa Maria Valley. Furthermore, by signing below, I authorize release of my medical records or medical information to any party that is partially or fully responsible for payment for my medical care (insurance, employer, etc.).

Signature

Today's Date