PATIENT DEMOGRAPHICS

Houston/Heights Office
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Houston TX 77007
Phone: 713-802-0801
Fax: 713-802-0105
fdhouston@
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Port Arthur Office
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Port Arthur TX 77642
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Deer Park Office
321 W. San Augustine
Deer Park TX 77536
Phone: 281-476-4616
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North Houston Office
15621 Blue Ash Dr. Ste 170
Houston TX 77090
Phone: 281-893-0521
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fd1960@
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Lake Charles Office
3730 Nelson Road
Lake Charles, Louisiana
70605
Phone: 337-656-7703
fdlakecharles@
occucareinternational.com-
com

Employee ID: **SSN#:**

First Name: **Last Name:** **Nick Name:**

Address:

City: **State:** **Zip:**

Home Ph: **Cell Ph:**

eMail: **DOB:** **Gender:**

Race: **Marital Status:** **Preferred Language:**

Drivers License: **Class:** **State:**

Medical Authorization Release

Please read following statement and if you agree, sign and date.

"I declare that the above information and medical history to be true to the best of my knowledge."

"I agree to the release of information related to my fitness for duty, accommodations that may be needed for me to perform essential job functions and/or prognosis for a return to employment.

You may refuse to sign this authorization. However, a refusal to sign this authorization may have employment consequences."

I, ___________________________, accept the transfer of my medical files and test results to the authorized company representative for appropriate review.

HIPAA Notice of Privacy Practices

"We are required to provide you with a copy of our notice of privacy practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

I, ___________________________, acknowledge thatI was given the opportunity to review a copy of Occucare's notice of privacy practices.

Signature of Examinee: ____ **Date:** _____________