 **Patient**

 **Information**
307 S 12th AVE, Suite 12

 Yakima, WA 98902

Patient Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home PH: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cell PH: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Social Security #

How would you like to receive appointment reminders? Phone Text Email (circle options)

Email **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cell**/**Text# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Carrier**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** City: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ST: **\_\_\_\_\_** Zip: **\_\_\_\_\_\_\_\_\_**

Primary Care Physician: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Height**: \_\_\_\_\_\_\_\_\_\_** Weight: **\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Patient’s Occupation: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** City: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ST: **\_\_\_** Zip: **\_\_\_\_\_\_\_\_**

Employer PH #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Fax #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How long have you worked for your current employer? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you currently working at job of injury? Y N

**L & I Information**

 Is this a work-related injury? Y N

 If yes, what was the date and time of the injury? Date: Time: AM PM

 If yes, have you filed an L & I claim? Y N

 If yes, where did you file the claim?

 **State L & I Claim #:** **Employer Self-Insured Claim #:**

**Emergency Contact Information**

 Emergency Contact Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Home Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cell Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*\*\*Notice: Video Surveillance Cameras in Use in Public Access Areas\*\*\****

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Revised04/09/2024