

# Health Risk Assessment

Satilla Health Services Employees



Health & Wellness Center

EMPLOYEE INFORMATION      Date: \_\_\_\_\_      Employee #: \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female  Part-Time  Full-Time

Division: \_\_\_\_\_ Dept: \_\_\_\_\_ SHS Health Plan:  Yes  No

Email Address: \_\_\_\_\_

## BIOMETRIC/MEDICAL INFORMATION (From Physical)

Height (in): \_\_\_\_\_ Weight: \_\_\_\_\_ Hips (in): \_\_\_\_\_ Waist (in): \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_      Physician: \_\_\_\_\_

## HEALTH HISTORY (Please answer all of the questions)

I smoke cigarettes or cigars?  Never smoked  Former smoker  Quit last year  Current - cigs/day \_\_\_\_\_

I exercise for more than 30 minutes on 4 or more days per week? Fitness Center: \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> I Have High Blood Pressure            | → | <input type="checkbox"/> BP Medications          |
| <input type="checkbox"/> I Have Diabetes (Type 1 ___ Type 2__) | → | <input type="checkbox"/> Blood Sugar Medications |
| <input type="checkbox"/> Coronary Artery Disease               | → | <input type="checkbox"/> Heart Medications       |
| <input type="checkbox"/> High Cholesterol                      | → | <input type="checkbox"/> Cholesterol Medications |
| <input type="checkbox"/> COPD or other chronic lung condition  | → | <input type="checkbox"/> COPD Medications        |

## HEALTHY DIRECTIONS

(If you have earned more than 1000 wellness incentive points since your last physical, you qualify for a wellness incentive. Please indicate your choice below:

\$360 Insurance premium discount (\$13.85 per pay period for the year)

\$180 Check (taxes will be deducted)

## SATISFACTION

	Great	Good	OK	Fair	Poor
How satisfied are you with Satilla's Worksite Wellness Program:	5	4	3	2	1

Suggestions: \_\_\_\_\_

## ADDITIONAL RISK FACTORS (Staff Use only)

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Obesity (BMI > 30)        | <input type="checkbox"/> LDL > 160                         | <input type="checkbox"/> HDL < 35                        | <input type="checkbox"/> Total Cholesterol > 240 | <input type="checkbox"/> Triglycerides > 400 |
| <input type="checkbox"/> Level I (Bonus Incentive) | <input type="checkbox"/> Level 2 (Risk Reduction Programs) | <input type="checkbox"/> Level 3 (CAD High Risk Program) |  |  |

2004 Pioneer Street, Waycross, GA 31501 \* tel.- 912-284-2410 \*fax: 912-284-2386





Health & Wellness Center

## HEALTHY DIRECTIONS PRIVACY NOTIFICATION

By signing this form, an employee agrees to actively participate in Satilla's Healthy Directions, worksite wellness, program. Participating employees agree to maintain good health, or strive towards becoming healthier, depending upon their current health status. An employee agrees to participate in an annual HRA and physical, including routine lab tests, to become eligible for the Healthy Directions program.

Health information (from an annual physical, HRA, and other Personal Health Information) will be used to determine an employee's risk level in order to determine which programs and services are appropriate to offer. It is understood that Satilla Health Services (SHS), and those performing prevention and risk-reduction services on behalf of SHS, will have access to the health information of each employee who chooses to participate. Your company will not receive individual test results, but will have access to general health status information. However, this information will only be used for the purpose of managing prevention services and risk reduction programs on behalf of the company in order to improve the overall health of employees.

In signing this form, I willingly agree to participate in any and all programs specifically offered to me as a result of my risk level.

Reward incentives are in no way tied to your risk level or to any success in achieving better health through the programs in which you participate. Instead, health incentives are offered to you for merely **participating** in the screenings, HRA's, and any resulting programs offered to you as a result of your risk level.

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**Employee Name:** \_\_\_\_\_

**Employee acknowledgment:** I acknowledge that I have been provided an opportunity to review a copy of the privacy practices of Satilla's Healthy Directions program. I acknowledge that I have been provided the opportunity to ask questions regarding this notice and its contents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2004 Pioneer Street, Waycross, GA 31503, tel 912-284-2460, fax: 912-384-2389



## Satilla Regional Medical Center

### DRUG TESTING AUTHORIZATION AND RELEASE OF LIABILITY

I understand that in accordance with Satilla Health Services Drug and Alcohol Policy, employees and prospective employees are required to undergo a substance abuse test to determine whether the policy has been violated.

All drug tests are subject to careful testing procedures with mandatory confirmation of any preliminary positive tests.

I understand that I will be given a reasonable opportunity to explain the reason for any confirmed positive test result. Laboratory results of the drug test will be maintained in a confidential manner by the Manager of the Satilla Convenient Care.

I understand if I am referred for a drug test due to Reasonable Suspicion that I will be placed on an Administrative Leave pending the tests results and/or evaluation, treatment and release by the EAR

I understand if I am referred for a drug test due to a Random Test, an Annual Physical, a Post Rehab or Post Accident and the test is positive I will be placed on an Administrative Leave until which time there is a retest confirmation, referral to the EAP or appropriate disciplinary action is taken.

I voluntarily consent to provide a specimen at a collection facility or other location designated by Satilla Health Services promptly upon being asked to do so, and I further consent to having the specimen tested at a laboratory selected by Satilla Health Services.

I authorize the release of the drug test results to the MRO and designated Satilla Health Services management. I understand that if the drug test is part of a physical examination the results will also be disclosed to the examining physician.

I release Satilla Health Services, its employees, management and its designated medical or professional representatives, from any and all claims or causes of action resulting from this test, the release of the results of the test to such persons, and any employment decisions as a result of the test.

\_\_\_\_\_  
Print Employee or Applicant Name

\_\_\_\_\_  
Social Security # and Phone Number

\_\_\_\_\_  
Employee or Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Patient's ID



**SATILLA HEALTH SERVICES**  
**CONSENT TO ROUTINE PROCEDURES & TREATMENTS**

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**Important: Do not sign this form without reading and understanding its contents.**

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

- (1) Needlesticks, such as shots, injections, intravenous lines or intravenous injections for the purpose of medication administration, hydration and/or fluid therapy. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.
- (2) Physical tests, assessment and treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infections, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
- (3) Administration of Medications whether orally transdermally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
- (4) Drawing Blood for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, bruising (hematoma), inflammation of vein (phlebitis), and temporary nerve damage. Apart from long term observation and/or refusal of treatment, no practical alternatives exist,
- (5) Insertion of Internal Tubes such as urinary bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The materials risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control, and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.





**SATILLA REGIONAL MEDICAL CENTER  
SUMMARY OF NOTICE OF PRIVACY PRACTICES**

**Our Legal Duty:** We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

**Parties Following The Notice:** The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

**How We May Use and Disclose Medical Information About You:** We may use or disclose identifiable health information about you for many reasons, including:

- Treatment
- Payment
- Health care operations
- Health oversight activities
- Public health purposes
- Auditing
- National security and protective services
- Research
- Workers' compensation
- Lawsuits and disputes
- Activities of managed care networks in which we participate
- Activities of our affiliates
- Appointment reminders
- Fund raising activities
- Organ donation
- To avert a serious threat to health or safety
- To coroners, medical examiners and funeral directors
- To military command authorities
- As required by law

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories or for Individuals involved in your care.

**Your Privacy Rights:**

**You have the following rights with respect to your health information:**

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health information.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of your health information.

**Changes to the Notice:** We reserve the right to change the Notice. We will post any revised Notice in the Hospital.

**Complaints:** If you believe your rights have been violated, you may file a written complaint with the Hospital's Chief Privacy Officer Kathy Amsler @ 912-287-2619 or kathya@satilla.org or with the Secretary of the U.S. Department of Health and Human Services. Office of Civil Rights HIPAA Hotline (404)562-7886.

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**ACKNOWLEDGMENT**

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Patient Acknowledgment:** I acknowledge that I have been provided an opportunity to review a copy of the Notice of Privacy Practices for Satilla Regional Medical Center. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of individual or, if screening is for a minor, parent or legal guardian signature.)

**For Use by Hospital Personal Only:** [Complete if patient acknowledgment is not obtained]

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgment was not obtained because \_\_\_\_\_

Signature of Hospital Representative: \_\_\_\_\_ Date: \_\_\_\_\_



**SATILLA REGIONAL MEDICAL CENTER**  
**RESUMEN DEL AVISO SOBRE PROCEDIMIENTOS DE PRIVACIDAD**

**Nuestra obligacion legal:** Tenemos el deber de proteger, con caracter confidencial, los datos medicos sobre su persona. Se nos exige entregarle un Aviso sobre procedimientos de privacidad, que detalla las diversas formas en que tenemos derecho a utilizar y divulgar sus datos medicos. En este tambien se describen sus derechos y nuestras obligaciones sobre el uso y divulgacion de los datos medicos sobre su persona.

**Partes que cumplan con el Aviso:** Cumpliran con el Aviso el Hospital y sus afiliadas, los profesionales de atencion a la salud, el personal y los voluntarios de estos; el plantel medico del Hospital y aquellas personas que participen con el Hospital en redes de atencion administrada; asi como y otras entidades juridicas que presten servicios al Hospital.

**Uso y divulgacion de los datos medicos sobre su persona:** Tenemos derecho a utilizar o divulgar datos de salud identificables con su persona por varios motivos, entre ellos los siguientes:

- Tratamiento
- Pago de honorarios
- Procedimientos en materia de atencion a la salud
- Actividades de supervision sanitaria
- Fines de salud publica
- Auditorias
- Seguridad nacional y servicios de proteccion
- Investigaciones
- Indemnizacion por accidentes de trabajo
- Juicios y disputas
- Actividades de las redes de atencion administrada en las que participemos
- Actividades de nuestras afiliadas
- Recordatorios de citas
- Campanas de recaudacion de fondos
- Donacion de organos
- Para evitar una amenaza grave a la salud o seguridad personal
- A medicos forenses y directores de empresas funebres
- A autoridades militares
- En los casos exigidos por ley

Por lo general, usted debera otorgar una autorizacion escrita para otros casos de uso y divulgacion de sus datos medicos. Tenemos derecho a utilizar o divulgar ciertos datos limitados sobre su persona, a menos que usted lo objete o solicite que se limite la divulgacion, en los siguientes casos: • Directorios de hospitales • Personas que participan en su atencion medica o pago de honorarios

**Sus derechos de privacidad:**

Usted tiene los siguientes derechos con respecto a sus datos de salud:

- El derecho de solicitar comunicaciones con caracter confidencial y otras formas de comunicacion dirigidas a usted.
- El derecho de solicitar restricciones en ciertos usos de los datos de salud.
- El derecho de inspeccionar y copiar ciertos datos medicos que consten en nuestros archivos.
- El derecho de solicitar una modificacion de sus datos de salud.
- El derecho de solicitar un listado de ciertos casos en que se han divulgado sus datos de salud.

**Modificaciones del Aviso:** Nos reservamos el derecho de modificar el Aviso, y anunciaremos el Aviso actualizado en el Hospital.

**Quejas:** Si cree que se han violado sus derechos, podra presentar una queja por escrito ante el Hospital (Kathy Amsler @ 912-287-2619 ) o ante el Secretario del Departamento de Salud y Servicios Humanos de EE.UU. (U.S. Department of Health and Human Services).Office of Civil Rights HIPAA Hotline (404)562-7886.

**RATIFICACION**

**Nombre del paciente:** \_\_\_\_\_ **edad** \_\_\_\_\_

**Ratificacion del paciente:** Ratifico haber recibido una copia del Aviso sobre procedimientos de privacidad correspondiente al Hospital \_\_\_\_\_ Asimismo, ratifico que se me ha concedido la oportunidad de formular preguntas sobre el Aviso.

**Firma del paciente:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_  
La firma de individuo o, si la investigacion es para un menor, el padre o firma legal de guardián.

**Para uso exclusivo del personal del Hospital:** [Llenar si el paciente no firmo la ratificacion]

Se le entrego al paciente una copia del Aviso sobre procedimientos de privacidad y se intento de buena fe hacer que este lo firmara como acuse de recibo del Aviso. No fue posible obtener la ratificacion porque \_\_\_\_\_

**Firma del representante del Hospital:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_



# SATILLA CONVENIENT CARE PATIENT HISTORY FORM

"The following information is very important to your health. Please take the time to fully and accurately fill out this form."

Name: \_\_\_\_\_  
Last
First
Middle Initial
Date of Birth:
Social Security Number:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City
State
Zip

Date of Last Physical: \_\_\_\_\_ Private Physician: \_\_\_\_\_

Present State of Health: **(Circle One)**      Excellent      Good      Fair      Poor

Occupation: \_\_\_\_\_ Immunizations Up-To-Date: Yes\_\_\_\_ No\_\_\_\_

Do you have difficulty with written material? Yes\_\_\_\_ No\_\_\_\_

Do you utilize any of the following services? **(check if applicable)** Medical equipment/medical supply agency \_\_\_\_\_

Home health agency \_\_\_\_\_ Rehab service \_\_\_\_\_

Primary Language: \_\_\_\_\_

Are there any physical limitations that keep you from doing what you need/like to do? \_\_\_\_\_

Do you have difficulty: **(check if applicable)** obtaining medications \_\_\_\_\_ obtaining transportation \_\_\_\_\_  
 obtaining food \_\_\_\_\_

Do you have any special needs related to your cultural or religious beliefs? \_\_\_\_\_

Do you have any problems with food intake? \_\_\_\_\_

Do you **(check if applicable)**: live alone with disabilities \_\_\_\_\_ live alone without disabilities \_\_\_\_\_

live with others who can assist with care \_\_\_\_\_ live with others who can not assist with care \_\_\_\_\_

**ALLERGIES:**

List all medicines, shots, foods and/or insect stings to which you are allergic:

ALLERGY	REACTION	ALLERGY	REACTION

**MEDICATIONS:**

List all medications you regularly take or are now taking (including over-the-counter medications, herbals and nutritional supplements):

MEDICATION	DOSE	FREQUENCY	REASON PRESCRIBED

**OPERATIONS:**

List all operations you have had and the approximate date:

DATE	OPERATION/PROCEDURE

**PREVIOUS HOSPITALIZATIONS:**

List dates and reasons for hospitalizations:

DATE	REASON FOR HOSPITALIZATION

Patient's ID



**MEDICAL HISTORY: HAVE YOU EVER HAD OR DO YOU NOW HAVE?:**

	Yes	No		Yes	No		Yes	No		Yes	No
arthritis, frozen joints			diabetes, thyroid disease			hernia			pneumonia		
asthma, bronchitis			drug problem			hepatitis			rheumatic fever		
back trouble of any kind			epilepsy (seizures)			high blood pressure			stomach trouble or ulcers		
blood clots or varicose veins			fainting spells			IV drug use			tuberculosis, silicosis		
blood transfusions, hemophilia			foot problems			kidney trouble			veneral disease		
cancer			hearing difficulty			measles			do you smoke or use tobacco products?		
chicken pox			heart trouble			mumps			do you drink alcoholic beverages?		
dermatitis (skin condition)			hemorrhoids (piles)			nervous or mental illness			do you use drugs? (recreational)		
									do you have menstrual problems		

**WHAT OTHER INJURIES OR ILLNESSES HAVE YOU HAD THAT WERE SERIOUS?**

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**FAMILY HISTORY:**

Has any blood relative ever had the following:

MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
CANCER			STROKE		
TUBERCULOSIS			SEIZURES		
DIABETES			MENTAL ILLNESS		
HIGH BLOOD PRESSURE			MIGRAINE HEADACHE		
HEART TROUBLE			OTHER		

List age, general state of health, diseases present or age at death and cause of death of your relatives:

RELATIVE	AGE	GENERAL STATE OF HEALTH Excellent, Good, Fair, Poor	DISEASES PRESENT	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
BROTHER					
BROTHER					
SISTER					
SISTER					
SISTER					
CHILD					
CHILD					
CHILD					

"I attest that the above information is true and correct to the best of my belief."

\_\_\_\_\_  
Patient or Parent/Guardian

\_\_\_\_\_  
Date

I give permission for a representative from Satilla Convenient Care to call me and check on my progress.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Healthy Directions

## Satilla's Worksite Wellness Program

**I** Screen all employees annually for risk factors for cardiovascular disease. Every employee has an annual physical, along with a free lab profile, and completes a health risk assessment. This is part of SHS annual update requirements.

**Risk Factors**

- Male age 45+/Female age 55+
- Immediate family history of CAD or stroke
- Cigarette Smoker (Automatic Level II)
- Diabetic
- Current Chest Pains (Automatic Level III)
- Sedentary Lifestyle
- Hypertension
- Obesity, BMI > 30
- LDL > 160
- HDL < 35

**Lab Values (abnormal)**

- Cholesterol > 240
- Glucose > 125
- Triglycerides > 400

**II Risk stratify employees**

Level I	Normal labs, less than three risk factors	- LOW Risk
Level II	Abnormal labs & less than three risk factors Normal labs & 3 three risk factors Smoking is automatic Level II	- MODERATE Risk Prevention
Level III	Abnormal labs and 3 or more risk factors Current Chest pains, Previous cardiac event, Diagnosis of Chronic Disease (CAD, Diabetes, CHF, Uncontrolled Hypertension, Hyperlipidemia)	- HIGH Risk Preventing future

**III Risk Reduction and Incentive Programs**

- Incentive bonus for maintaining good health - \$360 HRA/\$180 Check/\$30 per month
- Premium discount - Level I (Level II/III must earn by participating in risk reduction)
- Nutrition counseling with a Registered Dietician. - Level II/III
- Pharmacy consults - Medication therapy management - Level III
- YMCA exercise program/membership - Level II/III
- Fitness memberships. (Accountable for monthly attendance) - Level II/III
- Weight Watchers - Employees with BMI > 30, fees paid by Satilla. All other employees pay ½ price, SHS pays ½ price.
- If abnormal labs - Refer to personal physician - Level II, III
- CAD High Risk program (6 weeks), Stress Test/EKG - Level III
- Employee Rx Assistance - a program to assist employees with chronic illnesses in getting their chronic medications, to ensure compliance and controlling risks.
- Smoking Cessation assistance for all smokers. One-to-one or group counseling, referrals to the Georgia Quit Line, SRMC will provide pharmaceutical aids



SATILLA CONVENIENT CARE  
1921 ALICE STREET, SUITE 4A.  
WAYCROSS, GA 31501

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Marital Status:  Married  Divorced  Widowed  Single  Separated  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ email: \_\_\_\_\_ ok to contact by email  yes  no  
Work Status:  F/T  P/T  Self Emp  Active Military  Unemp  Retired  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_ Retire date: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY OR SPOUSE (CIRCLE ONE) INFORMATION**

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Relation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_ Retire Date: \_\_\_\_\_  
Employer Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance:  
Insurance Company: \_\_\_\_\_ Co-Pay \$ \_\_\_\_\_  
Billing Address : \_\_\_\_\_ ID # \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective : \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Insured's SSN : \_\_\_\_\_ Insured's Date Of Birth : \_\_\_\_\_

Secondary Insurance:  
Insurance Company: \_\_\_\_\_ Co-pay # \_\_\_\_\_  
Billing Address : \_\_\_\_\_ Policy # \_\_\_\_\_  
Group Name : \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Relation To Patient : \_\_\_\_\_  
Insured's SSN: \_\_\_\_\_ Insured's Date Of Birth : \_\_\_\_\_

Is your visit related to an accident  Y  N Work Related  Y  N  
Auto Accident  Y  N Accident Date \_\_\_\_\_ Accident Location: \_\_\_\_\_  
Responsible Insurance : \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Responsible Party \_\_\_\_\_

