

Longview Clinic
 3331 Washington Way
 Longview, WA 98632
 360.578.2527 voice
 360.575.1460 fax
 www.hwnw.org



Chehalis Clinic
 1595 N. National Ave #2
 Chehalis, WA 98532
 360.740.0444 voice
 360.740.0704 fax
 www.hwnw.org

PATIENT INFORMATION RECORD

Patient Information

Last _____ First _____ M.I. _____

Address _____

City _____ State _____ ZIP _____

Birthdate ____/____/____ Your Phone Number () _____

Social Security Number ____/____/____ Company _____

Who is your primary care provider (doctor)? _____

SEX Male Female **MARITAL STATUS** Single Married Widowed Separated/ Divorced

RACE White African-American Asian Hispanic Indian Other

Why are you here today?

<input type="checkbox"/> Urine Drug Screen	<input type="checkbox"/> D.O.T. (Driver) Physical Exam	<input type="checkbox"/> Hearing Test	<input type="checkbox"/> Physical	<input type="checkbox"/> Injury care
<input type="checkbox"/> Respiratory Certification <input type="checkbox"/> Fit Test	<input type="checkbox"/> Pulmonary Function Test	<input type="checkbox"/> Vaccination	<input type="checkbox"/> Breath Alcohol Test	<input type="checkbox"/> Follow Up Care for Injury
<input type="checkbox"/> Blood Lead Profile	<input type="checkbox"/> CBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other

I authorize HealthWorks Northwest to release any medical records pertaining to my medical surveillance (e.g., audiogram, PFT, Respirator Certification, Physical exam), or injury care to the employer's designated company representative.

If I am being seen for an industrial/occupational injury, I understand that in the event the claim for this injury is not accepted, I will be responsible for providing my private insurance information to HealthWorks Northwest for billing. If I do not have private insurance, I agree to be responsible for charges I incur.

Signature _____ Date: _____