

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: \_\_\_\_\_