NEW CLIENT INFORMATION
SERVICES REQUESTED

Company Name: ______________________________________ Todays Date: _______________________________

Company Address: ____

Phone Number: _________________________________ Fax Number: _____________________________________

Contact Person: _________________________________ Position at Company: _______________________________

Cell Number: __________________________________ Email: ____

Send reports via: ☐ Fax ☐ E-Mail ☐ Mail ☐ Other ____

Billing Information:

Billing Address: ____

Accounts Payable Contact: ____

Worker's Comp Information:

Worker's Comp Insurance Company: ____

Insurance Address: ____

Insurance Phone: __________________________________ Policy Number: ___________________________________

Services Requested:

Physical Examination Type: ____

Breath Alcohol Test: ☐ DOT ☐ NON-DOT

Drug Screen: ☐ DOT ☐ NON-DOT ☐ Quick Screen ☐ Hair ☐ Other _______________________________

Additional Test: ☐ Other _______________________

Injury Treatment:

Post-Accident Drug Screen: ☐ DOT ☐ NON-DOT ☐ Quick Screen

Post-Accident Breath Alcohol Test: ☐ DOT ☐ NON-DOT

For Office Use Only!

Clinic Location_________________________________ Patient ID _________________________________

Please email this information to: lhunt@phcurgentcare.com
Or fax this information to: (337) 981-5466