## State Drug Testing & Occupational Health, Inc.

## Patient Information Sheet

Employers Name: ______________________________________________________________

Reason for Visit: Pre-Employment Random Reasonable Suspicion/Cause

Post-Accident Return To Duty Follow-up

Other (Specify): _________________________________________________

**Injury Information (If applicable):**

Date of Injury/Illness: _____________________ Time of Injury/Illness: ___________________

Have you been treated elsewhere for this injury listed above? Yes _____ No _____

If yes, where or by whom? ________________________________________________________

**Patient Information:**

Social Security: ________- _______- _______ Name to be called: _____________________

First Name: ___________________________ Last Name: __________________________

Street Address: ____________________________________________________________

City: __________________________ State: _________________ Zip: ___________________

Phone Number: ____________________________________

E-mail Address: ____________________________________________________________

Date of Birth: ____________________________ Gender: _____________________________

**DOT Information:**

Driver's License Number: ____________________________ State: ___________________

CDL/CLP: ________________ Class: _______________________

**Emergency Contact:**

Name: _________________________________ Phone: _______________________