Premier FAMILY CARE
First in Convenience... First in Compassion

Broken Arrow URGENT CARE

Drug Screening

PATIENT INFORMATION

Check In Time _____ Check Out Time _____

Last Name_____ First Name_____Middle Initial_____

DOB _____ Gender: **Male Female** SS Number_____ Marital Status: **M S W D**

Drivers License Number _____ Exp:_____

Phone (Home) _____ (Work) _____(Cell)_____

Home Address _____

City_____ State _____Zip _____

Employer_____ Employer Phone # _____

COMPANY INFORMATION

Company Requesting Test_____

Address _____

City_____ State _____Zip _____

Contact Person _____ Phone #_____

REASON FOR VISIT

- ❑ Pre-Employment Physical Only
- ❑ Pre-Employment Physical and Drug Screen
- ❑ Random D/S
- ❑ DOT Physical Only
- ❑ DOT Physical/Drug Screen
- ❑ Pre-Employment Drug Screen Only
- ❑ Workman's Comp Post Accident Drug Screen
- ❑ Health Risk Assessment
- ❑ DOT Drug Screen Only

IN CASE OF EMERGENCY

Emergency Contact (Name) _____

Phone _____ Relationship _____

_____ _____

Patient Signature Signature of Parent or Guardian of minor

_____ _____

Date Date

Rev 1-9/10