Bee Well

URGENT CARE

PATIENT MUST PRESENT PHOTO ID AND AUTHORIZATION FORM AT THE TIME OF SERVICE

FORM AUTHORIZING EXAMINATION OR TREATMENT

EMPLOYER INFORMATION

Employer:		Employer Contact Phone:	
Employer Contact Person:		Bee Well Account Number:	

PATIENT INFORMATION

First Name:		Last Name:		Middle Initial:	
Date of Birth (MM/DD/YYYY):		Social Security Number:			

REQUESTED SERVICES

Drug Screens **Authorized Services:** In Office Send Out

Pre-Employment Drug Screen Post-Accident Drug Screen Random Drug Screen DOT Drug Screen

Physicals	**Diagnostic**	**Other**
Non-DOT/Pre-employment	Blood Work	Tetanus and Diphtheria (Td)
Fit for Duty	Urine Analysis	
DOT/DOE Physical	X-Ray	
Basic Physical	Wound Eval/Repar/Treatment/Culture	
	Splinting	
	Other ________________	

Workers' Compensation

Injury Illness	Injury/Illness Details:	
Billing Directions:	Employer	Worker Compensation Insurance ________________

NOTES AND ADDITIONAL SERVICES

EMPLOYER AUTHORIZATION

Signature:		Date (MM/DD/YYYY):	