

Centegra Occupational Health Client Profile

Company Name: _____ **Date:** _____

Please check which applies: New Client Set up: _____ Updating Existing Client Profile: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Number of Employees: _____ How many are local: _____

Primary Contact: _____ **Title:** _____

Phone Number: _____ Cell Number: _____

Fax: _____ Is fax confidential/private: Yes ___ No ___

Email: _____

Secondary Contact: _____ **Title:** _____

Phone Number: _____ Cell Number: _____

Email: _____

Billing Information

Address for cash pay services: Same as above: _____ If different address or contact than above,
please provide: _____

Workers Compensation Insurance Provider: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Contact for claim numbers, etc.: _____

Phone Number: _____ Fax Number: _____

Email: _____

Pre-Employment Requirements*: Drug Screen _____ What kind? _____

Physical (indicate what type): _____

Other requirements(screens): _____

*If requirements different for certain positions, please note on separate sheet.

Post-Accident/Injury Requirements: Drug Screen _____ What kind? _____ Alcohol Screen _____

How should we send results (choose one): Fax _____ Email _____

Who should receive results of screens and injury visits: _____

Signed by (print) _____ Signature: _____

Scan and email to Dave Matts dmatts@centegra.com