The Hospital of Central Connecticut
A Hartford HealthCare Partner

Demographic Information

Patient Last Name _____ Patient First Name_____ MI_____

Suffix _____ Birthdate: _____ SSN# _____Gender _____

Address: _____

City _____ State _____ Zip Code _____

Phone _____ Work/Cell _____

Primary Care Physician: _____

Employer name_____ Employer's phone: _____

Location/Store # _____ Supervisor: _____

Emergency information

Emergency Contact: _____ Relationship: _____

Phone _____ Work/ Cell _____

Purpose of visit

Circle Non- Injury purpose for visit:

- o DOT Physical
- o Pre-Employment Physical
- o Physical Therapy
- o Drug Screen Only
- o Physical and Drug Screen
- o Annual/Bi-annual
- o Audiogram
- o HazMat/Environmental
- o Random
- o Post-Accident
- o Other: explain _____

You may contact my employer to verify the purpose of my visits if necessary

Signature: _____ Date: _____

Please return this with your driver's license or picture ID.