

**FREMONT URGENT CARE CENTER**

3161 Walnut Ave.  
Fremont, CA 94538  
(510) 796-1000 Fax 796-1060

**NEW COMPANY INTAKE QUESTIONNAIRE**

Name of Company: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ x \_\_\_\_\_

Worker's Compensation Insurance Company

Name : \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Do you want us to contact your company after your employee's visits to Fremont Urgent Care?

No, no call is necessary.  Yes, after first visit only  Yes, after each visit with the doctor

Yes, but only if something significant has changed.

Do you want us to fax the work status form to you?  Yes  No

If yes, what is the number of the **confidential** fax? \_\_\_\_\_

Please note this must be a **confidential** fax, with access limited only to authorized personnel.

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**Indicate the services you would like us to perform:**

Workers Compensation Only

**Post Worker's Compensation Injury:**

Drug Screen (Urine)                       Breath Alcohol Testing                       Saliva Alcohol Testing

Instant Drug Screen (Positive confirmed with lab)

If you want a urine drug screen performed, what lab do you want us to use?

Fremont Urgent Care's lab

Your lab. If your lab, please list the name here and supply us with Chain of Custody forms.

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**Pre-employment:**

Physical Exam

Drug Screen DOT

Drug Screen non-DOT

Instant Drug Screen (positive confirmed with lab)

Drug Screen DOT-lookalike

Hazmat Exam

Respirator Exam

Spirometry

EKG

Chemistry Panel

DOT exam

CBC

Urinalysis

Treadmill EKG

Functional Capacity Testing

Basic Back Evaluation

Chest X-ray

Back X-rays (Spondylolisthesis Screen)

Urine Arsenic

Other \_\_\_\_\_

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**Medical Surveillance:**

Physical Exam

Drug Screen DOT

Drug Screen non-DOT

Drug Screen DOT-lookalike

Hazmat Exam

Respirator Exam

Spirometry

EKG

Chemistry Panel

DOT Exam

CBC

Urinalysis

Treadmill EKG

Functional Capacity Testing

Basic Back Evaluation

Chest X-ray

Back X-rays (Spondylolisthesis Screen)

Urine Arsenic

Other \_\_\_\_\_

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How do you want us to notify you of the physical exam results? (Pick one or more)

- |                                    |                                 |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Telephone | <input type="checkbox"/> Letter |
| <input type="checkbox"/> Fax       | <input type="checkbox"/> email  |

Name of contact: \_\_\_\_\_

Phone number \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Please note that the fax must be a **confidential** fax.

Are there any comments?

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Name of person filling out this form: \_\_\_\_\_

Please fax this form to 510-796-1060. Any questions, please call Dr. Giddens at 510-796-1000 x21 or Cindy Lofthouse at 510-796-1000 x14.