STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS	**PLEASE DO NOT USE THIS COLUMN**
2. **EMPLOYER NAME**	**Case No.**
3. Address No. and Street City Zip	**Industry**
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)	**County**
5. **PATIENT NAME** (first name, middle initial, last name) / 6. Sex ☐ Male ☐ Female / 7. Date of Birth Mo. Day Yr.	**Age**
8. Address: No. and Street City Zip / 9. Telephone number ( )	**Hazzard**
10. Occupation (Specific job title) / 11. Social Security Number - -	**Disease**
12. Injured at: No. and Street City County	**Hospitalization**
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _____ a.m. _____ p.m. / 14. Date last worked Mo. Day Yr	**Occupation**
15. Date and hour of first examination or treatment Mo. Day Yr. Hour _____ a.m. _____ p.m. / 16. Have you (or your office) previously treated patient? ☐Yes ☐ No	**Return Date/Code**

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shallnot affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐Yes ☐No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐Yes ☐No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐Yes ☐No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐Yes ☐No
If "no", date when patient can return to: Regular work ____/____/____
Modified work ____/____/____ Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor Name and Degree (please type) _____ IRS Number _____

Address _____ Telephone Number (_____)_____

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representationfor the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Bear Valley Urgent Care
12186 Hesperia Rd. Victorville, Ca, 92395
Ph: (760) 381-8848 | Fax: (760) 381-8810

Occupational Health

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ ☐ Female ☐ Male SSN: _____-_____-_____
Mailing Address: _____ Apt/Suite/Unit:_____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email: _____
Marital Status: Married • Single • Divorced • Separated • Widow • Prefer not to answer
Race: White • African American • Asian • Eastern • Other:_____ Ethnicity: _____
Employer: _____ Occupation: _____
Address: _____ Phone #: _____
Emergency Contact: _____ Phone: _____ Relationship:_____
Emergency contact is required by your insurance, if you REFUSE to provide one, please initial here: _____
Date of Injury : _____ Time: _____AM / PM Place:_____
Accident reported to employer: [ ] Yes [ ] No Name of person you reported to:_____
Describe how accident or exposure happened. Give specific object, machinery or chemical.

_____

_____

Have you been seen by another Doctor for this injury? [ ] Yes [ ] No If yes where:_____

What is your pain level today?

_____

Medical History:

High Blood Pressure	Yes	No
Diabetes 1 / 2	Yes	No
Ulcers	Yes	No
Heart Murmur / Valve Disorder	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Cancer: _____	Yes	No
Gallstones	Yes	No
Kidney Stones	Yes	No
Blood Transfusion	Yes	No
Immunological Disorders	Yes	No
Diverticulosis	Yes	No

Thyroid Problems	Yes	No
Asthma	Yes	No
C.O.P.D	Yes	No
Depression	Yes	No
Anxiety	Yes	No
High Cholesterol	Yes	No
Other: _____	Yes	No

Alcohol Use	Yes	No
Tabacco Smoker	Yes	No
Recreational Drugs	Yes	No

Surgeries Year
1. _____
2. _____
3. _____

Allergies: Reaction
1. _____
2. _____
3. _____

Medications: Dosage/Frequency
1._____
2._____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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Have you ever …	YES	NO	**Have you ever …**	YES	NO
Worn glasses or contact lenses?			Had a kidney problem?		
Had an eye injury?			Experienced shortness of breath outside of exercise?		
Had eye surgery?			Had severe headaches or migraines?		
Had an eye disease?			**Do you have …**		
Had any lung or respiratory issues (bronchitis, tuberculosis, asthma)?			Any permanent disabilities?		
Had poliomyelitis?			Any conditions of the bones or joints (amputations, dislocations, or broken bones)?		
Had hepatitis, jaundice or other similar ailments?			Sensitivity to dust or smoke?		
Been diagnosed with anemia or other blood disorders?			Any problems with your hearing?		
Had a mental illness?			A speech impediment?		
Suffered from stress related problems?			A history of addiction to drugs?		
Been diagnosed with a disorder of the nervous system?			Any existing temporary medical conditions such as broken bones or are recovering from surgery?		
Had a seizure?			**Family History**		
Had sudden loss of consciousness?			Blood disease		
Had an illness, work injury, or physical condition which required treatment as an outpatient or where surgery was recommended?			Cancer / leukemia		
Been diagnosed with rheumatism, arthritis, or bursitis?			Diabetes		
Had a back injury?			Heart disease		
Had any problems in the hips, knees, ankles, or feet?			High blood pressure		
Had any problems with your hands, elbows, or shoulders?			**For Women Only**		
Had prior hear injury or trauma?			Are you pregnant?		
Had skin troubles or rashes due to medication or chemical exposure?			Date of last menstrual period		
Had a hernia or rupture?					

Please explain *all* the questions marked *yes* above.

_____

_____

_____

_____

Agreement and consent: By signing below, I am stating that all the information provided above is true and factual as of the date below. I understand the questions fully and understand that by withholding or misrepresenting my medical history depending on the company protocols may be considered as an attempt of fraud and may result in my termination from my employment and/or rejection of my workers compensation claim.

Patient signature:_____**Date**_____

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Last Name: _____ First Name: _____ Middle Initial: _____

CONSENT TO MEDICAL SERVICE: The undersigned consent to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical treatment or procedures, services rendered to the patient under the general and special instructions of the patient's physician, and to participate in the patient and employee protection program.
ePRESCRIBE: The undersigned authorizes **Bear Valley Urgent Care** to request and use patient's prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

RELEASE OF INFORMATION: The urgent care may disclosure all or any part of the patient's record to any person, company or corporation which is or may be liable under a contract to the urgent care or to the patient or to a family member or employer of the patient for all or part of the urgent care charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation, or welfare funds. The patient's record may be forwarded to the primary care physicians or to another facility in the event of transfer.

FINANCIAL RESPOSABILITY: All services rendered to the patient are charged directly to the patient in the event that the claim for workers compensation is denied or terminated.

Relationship to Patient: Self • Mother • Father • Other: _____

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the assignment of insurance benefits.

_____	_____	_____
Signature of Patient/Guardian/Legal Representative	**Print Name/Relationship**	**Date**