

Brunswick Princeton Industrial Medical Center Client Information

	Date: _____
1. Company Information	Completed by: _____
Company Name: _____ No. Employees: _____	
Address: _____	
City: _____ State: _____ Zip: _____	
Phone: _____ Fax: _____ Pager: _____	
Type of Business: _____ Cell: _____	

2. Contact Information		
1. Name: _____		email: _____
Title: _____	Phone: _____	Fax: _____
2. Name: _____		email: _____
Title: _____	Phone: _____	Fax: _____

3. Billing Information

A) Injuries: Workers' Compensation Claims to: _____

Billing Address: _____
City: _____ State: _____ Zip: _____
Title: _____ Phone #: _____

B) Physicals/Drug Screens/Immunizations (non-injury) - (complete only if different)

Type: (DOT, Collection-Only, etc...) _____

Billing Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Title: _____
Protocol: Yes No Phone #: _____

C) Other Services: (Wellness Programs, Health Fair, etc...) _____

Billing Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Title: _____
Protocol: Yes No Phone #: _____

7. Referral Information

Referral Preferences:

Orthopaedic: _____

Physical Therapy: _____

Ophthalmology: _____

Pharmacy: _____

Other: _____

Other client specific information:
