Mount Sinai Selikoff Centers for Occupational Health

Participant Enrollment Form

DIA Total Worker Health™ Program

PARTICIPANT INFORMATION		
Last Name: **First Name:** **Middle Name:**		**Social Security Number:**
Address:	**City, State**:	**Zip**:
Cell/Mobile Phone: ( )	**Home Phone**: ( )	**Preferred Phone**: ( )
Email Address:	**Date of Birth:**	**Gender:** ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced		**Residence:** ❑ Rent ❑ Own
Do you have a primary care physician? ❑ Yes ❑ No **If yes, last date of visit** _____		
Do you want to see a MSSM primary care physician? ❑ Yes ❑ No		
Ethnicity: ❑ Hispanic or Latino or Spanish Origin ❑ Non Hispanic or Latino or Spanish Origin		
Race: ❑ African-American ❑ Caucasian ❑ Pacific Islander ❑ American Indian ❑ Hispanic/Latino ❑ Unknown ❑ Asian ❑ Other		**Preferred Language:**

IN CASE OF EMERGENCY		
Please Notify in Case of Emergency:		**Relationship to Participant**:
❑ Check if address is the ***same*** as participant information.		
Address:		**City, State**:
Cell/Mobile Phone: ( )	**Home Phone**: ( )	**Preferred Phone**: ( )

Viridian Health Management (Viridian) is a national health and wellness company. The Mount Sinai Selikoff Centers for Occupational Health has partnered with Viridian to provide comprehensive health management programs. Viridian will facilitate the administration of the Health Impact Assessment (HIA).

By signing below, you agree to have Viridian Health Management contact you to complete the Health Impact Assessment (HIA) and allow the Selikoff Centers for Occupational Health access to your completed Health Impact Assessment (HIA) and individual health report.

Participant Name (Print):	
Participant Signature:	**Date:**

Mount Sinai *Selikoff Centers for Occupational Health*

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Participant Last Name:	Participant First Name:	Participant DOB:

INSURANCE INFORMATION		
Name of Financially Responsible Person (if different from participant):		**Relationship to Participant:** ❑ Spouse ❑ Parent ❑ Other
Address (if different from participant):	**Home Phone:**	**Work Phone:**
Primary Health Insurance:	**Plan Name:**	**ID/Policy Number:**
Policy Holder Name:	**Relationship to Participant:** □ Self □ Spouse □ Parent □ Other	**Group Number:**
Insurance Company Address:	**Insurance Telephone #:**	**Policy Effective Date:**
Secondary Health Insurance:	**Plan Name:**	**ID/Policy Number:**
Policy Holder Name:	**Relationship to Participant:** □ Self □ Spouse □ Parent □ Other	**Group Number:**
Insurance Company Address:	**Insurance Telephone #:**	**Policy Effective Date:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the ***Mount Sinai Selikoff Centers for Occupational Health*** and/or insurance company to release any information required to process my claims.	
Participant Name (Print):	
Participant Signature:	**Date:**
Responsible Party Name (If Different):	
Responsible Party Signature (If Different):	**Date:**