

**INTAKE FORM**

Office of Mechel M. Henry, M.D.  
1300 Clay St. Suite 600, Oakland, CA 94612  
Phone//Fax: 866-397-7772  
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<b>Appointment Date:</b>	<b>Appointment Time:</b>
<b>Requested by:</b>	
<b>Type of Exam (circle one): Applicant QME / Defense QME / Panel QME / AME / IME</b>	

<b>Patient Name:</b>		<b>SSN:</b>
<b>Address:</b>		<b>Birth date:</b>
<b>City</b>	<b>State</b>	<b>Zip:</b>
<b>Phone:</b>		

<b>Applicant's Attorney Name:</b>		
<b>Address:</b>		
<b>City</b>	<b>State</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>

<b>Defense Attorney Name:</b>		
<b>Address:</b>		
<b>City</b>	<b>State</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>

<b>Patient Job Title:</b>		<b>Employer:</b>
<b>Insurance Carrier:</b>		
<b>Adjustor's Name:</b>		
<b>Address:</b>		
<b>City</b>	<b>State</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>

<b>Date of Injury:</b>	<b>Claim #:</b>	<b>WCAB #:</b>
<b>Body Part(s) to be examined:</b>		
<b>Interpreter Needed:</b>	<b>Language:</b>	

**IMPORTANT NOTES/OFFICE POLICIES**

1. Signing this form authorizes all necessary testing for the above evaluation. 2. Please note that we request a two-week notice for cancellations. There is a \$400 cancellation fee if cancellations are made later than 2 weeks before the appointment. 3. It is mandatory that patients arrive 30 minutes prior to the actual time of their appointment in order to complete the necessary forms. 4. Please indicate whether the medical records are to be returned or discarded after the appointment. The costs of returning the medical records will be the responsibility of your office. Thank you.

**By my signature below I accept these policies.**

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Name Date