Welcome to the ACCESS OMNICARE – EMPLOYER SERVICES

Your Occupational Medicine partner in Health and Safety

Please complete this document and return it with your Driver's License

LAST NAME:	FIRST NAME:	MIDDLE NAME:	PREFERRED NAME:

SEX: GENDER	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	FORMER LAST NAME:
◯ MALE ◯ FEMALE			

ADDRESS:	APARTMENT #:	ZIP CODE:	CITY:

STATE:	HOME PHONE:	MOBILE PHONE:	WORK PHONE:

EMAIL ADDRESS: Used for appointment updates	HOW SHOULD WE CONTACT YOU?
	◯ HOME PHONE ◯ WORK PHONE ◯ CELL PHONE ◯ EMAIL

PREFERRED LANGUAGE:	RACE:	MARITAL STATUS:
		◯ MARRIED ◯ SINGLE ◯ DIVORCED ◯ PARTNERED

EMERGENCY CONTACT NAME:	RELATIONSHIP:	HOME PHONE:	CELL PHONE:

EMPLOYER or COMPANY NAME

EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP CODE:

EMPLOYER PHONE:	OCCUPATION:	EMPLOYER CONTACT:	YEARS OF EMPLOYMENT:

ALLERGIES:	◯ No Known Allergies	LATEX ALLERGY:	◯ YES ◯ NO

CURRENT MEDICATIONS:	◯ See attached list Last TETANUS vaccine date: _____ (Year is OK) ◯ Not known

SOCIAL HISTORY: *Your full Social History will be reviewed during your medical intake*			
SMOKER:	◯ NEVER ◯ FORMER ◯ CURRENTLY	ALCOHOL:	◯ NONE ◯ OCCASIONAL ◯ MODERATE ◯ HEAVY
CAFFEINE:	◯ NONE ◯ OCCASIONAL ◯ MODERATE ◯ HEAVY	EXERCISE:	◯ NONE ◯ OCCASIONAL ◯ MODERATE ◯ HEAVY
HOBBIES:	◯ SPORTING ACTIVITIES ◯ HIKING ◯ BIKING DESCRIBE:		

FOR CLINIC USE ONLY

Ht_____ Wt_____ BP_____ / _____ Pulse _____ O2 _____ RR _____ Temp _____ Pain _____ LMP: _____

Urinalysis: Leuk _____ Nit _____ Urobili _____ Protein _____ pH _____ Blood _____ Spec Grav _____ Ketone ____ Bili ____ Glucose _____

Vision: Distance **Uncorrected**: **R** 20/____ **L** 20/____ Near **Uncorrected**: **R** 20/____ **L** 20/____

Distance **Corrected**: **R** 20/____ **L** 20/____ Near **Corrected**: **R** 20/____ **L** 20/____ ☐ Glasses ☐ Contacts

Ishihara: ☐ Normal ☐ Abnormal Gross Hearing intact (forced whisper): ☐ RIGHT ☐ LEFT **Treating MA:** _____ Room:

CHECK IN: [ ] READY MA: [ ] VITALS: [ ] READY DOC: [ ] CHECK OUT: [ ]

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Please identify each of the conditions as 'Yes' or 'No' and then we will clarify the specifics

YES	NO	Date/Year Diagnosed	PAST MEDICAL HISTORY
			Allergies to the environment
			Anemia
			Anxiety
			Arthritis
			Asthma
			Back Pain
			Bipolar Disorder
			Birth Defects or Inherited
			Bladder or Kidney Problems
			Blood Disease
			Blood Transfusion
			Breast Cancer
			Cancer
			Congestive Heart Failure (CHF)
			Constipation
			COPD
			Coronary Artery Disease – Heart
			Depression
			Developmental or Behavioral
			Diabetes
			Diverticulitis
			Ear or Hearing Problems
			Eating Disorder
			Eczema
			Fatigue and/or Malaise
			Fibromyalgia

YES	NO	Date/Year Diagnosed	PAST MEDICAL HISTORY
			GI Problems
			Gout
			Headaches
			Heart Attack
			Heart Problems
			Heartburn or Reflux Esophagitis
			Hepatitis
			High Cholesterol or Lipids
			Hospitalizations
			Hypertension – Elevated Blood Pressure
			Hyperthyroidism
			Hypothyroidism
			Kidney Disease
			Kidney Stones
			Liver Disease
			Lung Disease
			Mental Illness
			MRSA condition or exposure
			Muscle, Joint, or Bone Problems
			Obesity
			Osteoporosis
			Ovarian Cancer
			Pulmonary Embolism
			Seizures or Epilepsy
			Skin Problems
			Stroke

Other:

Surgical History:

SURGICAL HISTORY: *Please include any surgeries or procedures you have had completed* ◯ No Surgical History		
PROCEDURE:	PROCEDURE DATE:	SPECIFICS OF THE PROCEDURE:

Work Injury History:

WORK INJURY HISTORY: *Please include any history Work Related Injuries in your Past (please use extra sheet if required)*		
CONDITION:	DATE OF INJURY:	INJURY SPECIFICS:

Print Name _____

CONSENT FOR EVALUATION AND TREATMENT

Authorization for Medical Services

I consent to medical treatment from Access Omnicare ("AOC"), its affiliates, physicians, and employees. Treatment may include any necessary examination, test, or medical procedures ordered by the medical providers to be performed by AOC staff. I understand I may refuse treatment at any time. If I am seeking nonregulated substance abuse testing, I authorize AOC to obtain a specimen of my urine, blood, saliva, breath, hair, or other specimen to determine the presence of drugs or alcohol. I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of my personal physician.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or have been given an opportunity to review the AOC Notice of Privacy Practices (NPP). I have had an opportunity to ask questions about it and received satisfactory answers. I may ask for a copy of the NPP or can view it electronically at http://www.accessomnicare.com

- If I am being treated as an urgent care patient for a non-work-related injury and I have health insurance, I assign to AOC all payments under the terms of my applicable insurance policies.
- If I am being treated as an urgent care patient for a non-work-related injury and I do not have health insurance, I understand I am responsible for payment. I have a right to ask for the charge amounts before electing treatment.
- If I am treated for a workers' compensation injury or illness, AOC will seek payment from the responsible payer, which is typically the employer or the employer's workers' compensation insurance carrier.
- If I am receiving employer-directed services (e.g. drug testing, physicals, medical surveillance) AOC will seek payment from the employer. I may be responsible for payment if allowed by State or Federal law.
- If I am responsible for payment and my account is referred to collections, I understand that I may have to pay collection expenses incurred by AOC.

By signing this form, I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given the opportunity to ask questions, and any questions have been answered satisfactorily.

Patient signature confirming:

Print Name: _____ Signature: _____ Date: _____

Spouse/Parent/Guardian/Conservator signature confirming:

Print Name: _____ Signature: _____ Date: _____

TION TO DISCLOSE
Protected Health Information to Employer

My employer or potential employer has sent me to Access Omnicare ("AOC") for testing, evaluation, or treatment. By signing below, I authorize AOC to disclose my protected health information in accordance with the following terms and conditions:

1. **REQUIRED**: Name of current or prospective employer _____.

2. If I have been sent to AOC for only a drug screen, my protected health information only includes the results of that drug screen. Otherwise, my protected health information can include the results of tests or evaluations, including diagnoses and medical history relevant to the tests and evaluations performed that my employer or prospective employer has ordered or requires.

3. AOC may disclose my protected health information to my employer, prospective employer, or to an entity designated to evaluate my suitability for (1) initial or continued employment or (2) other activity required by my employer, or any other disclosure required by law.

4. I understand that my health information may not be protected from further disclosure by some entities receiving my information under this authorization, and that AOC has no control over subsequent disclosures by other entities.

MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION

- This authorization will expire one year from the date of when I am no longer employed by the above named employer or one year from the date below, whichever is later.

- I can ask for a copy of the protected health information that will be disclosed. A processing and/or copying charge may apply as permitted by law.

- My treatment may not be conditioned on my signing of this authorization unless the sole purpose of my visit to AOC is for my employer or prospective employer to obtain health information about me.

- I have a right to not sign this authorization or to limit the information I authorize to be disclosed. However, refusal to sign this authorization may violate a condition of employment or prospective employment. Contact your employer for details.

- I may revoke this authorization at any time, but I must do so in writing to the clinic where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. Revocation of this authorization may carry consequences related to my employment or prospective employment. Contact your employer for details.

- I have a right to receive a copy of this authorization.

By signing this form I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

Patient signature confirming:

Print Name: _____ Signature: _____ Date: _____