

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:	
<input type="radio"/> MALE <input type="radio"/> FEMALE							
ADDRESS:			APARTMENT #:		ZIP CODE:		CITY:
STATE:		HOME PHONE:		MOBILE PHONE:		WORK PHONE:	
EMAIL ADDRESS: Used for appointment updates				HOW SHOULD WE CONTACT YOU?			
				<input type="radio"/> HOME PHONE <input type="radio"/> WORK PHONE <input type="radio"/> CELL PHONE <input type="radio"/> EMAIL			
PREFERRED LANGUAGE:		RACE:		MARITAL STATUS:			
				<input type="radio"/> MARRIED <input type="radio"/> SINGLE <input type="radio"/> DIVORCED <input type="radio"/> 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:	<input type="radio"/> No Known Allergies	LATEX ALLERGY:	<input type="radio"/> YES <input type="radio"/> NO
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CURRENT MEDICATIONS:	<input type="radio"/> See attached list
	Last TETANUS vaccine date: _____ (Year is OK) <input type="radio"/> Not known

SOCIAL HISTORY: <i>Your full Social History will be reviewed during your medical intake</i>			
SMOKER:	<input type="radio"/> NEVER <input type="radio"/> FORMER <input type="radio"/> CURRENTLY	ALCOHOL:	<input type="radio"/> NONE <input type="radio"/> OCCASIONAL <input type="radio"/> MODERATE <input type="radio"/> HEAVY
CAFFEINE:	<input type="radio"/> NONE <input type="radio"/> OCCASIONAL <input type="radio"/> MODERATE <input type="radio"/> HEAVY	EXERCISE:	<input type="radio"/> NONE <input type="radio"/> OCCASIONAL <input type="radio"/> MODERATE <input type="radio"/> HEAVY
HOBBIES:	<input type="radio"/> SPORTING ACTIVITIES <input type="radio"/> HIKING <input type="radio"/> 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/____	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts		
Ishihara: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Gross Hearing intact (forced whisper): <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT		Treating MA: _____ Room:
CHECK IN: [_____] READY MA: [_____] VITALS: [_____] READY DOC: [_____] CHECK OUT: [_____] <i>Page 1 of 4</i>			

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	YES	NO	Date/Year Diagnosed	PAST MEDICAL HISTORY
			Allergies to the environment				GI Problems
			Anemia				Gout
			Anxiety				Headaches
			Arthritis				Heart Attack
			Asthma				Heart Problems
			Back Pain				Heartburn or Reflux Esophagitis
			Bipolar Disorder				Hepatitis
			Birth Defects or Inherited				High Cholesterol or Lipids
			Bladder or Kidney Problems				Hospitalizations
			Blood Disease				Hypertension – Elevated Blood Pressure
			Blood Transfusion				Hyperthyroidism
			Breast Cancer				Hypothyroidism
			Cancer				Kidney Disease
			Congestive Heart Failure (CHF)				Kidney Stones
			Constipation				Liver Disease
			COPD				Lung Disease
			Coronary Artery Disease – Heart				Mental Illness
			Depression				MRSA condition or exposure
			Developmental or Behavioral				Muscle, Joint, or Bone Problems
			Diabetes				Obesity
			Diverticulitis				Osteoporosis
			Ear or Hearing Problems				Ovarian Cancer
			Eating Disorder				Pulmonary Embolism
			Eczema				Seizures or Epilepsy
			Fatigue and/or Malaise				Skin Problems
			Fibromyalgia				Stroke
Other:							

Surgical History:

SURGICAL HISTORY: <i>Please include any surgeries or procedures you have had completed</i>			<input type="radio"/> No Surgical History
PROCEDURE:	PROCEDURE DATE:	SPECIFICS OF THE PROCEDURE:	

Work Injury History:

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

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: _____



AUTHORIZATION 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: _____

ACCESS OMNICARE PRE-CLINIC CHECK-LIST

Patient Name:		Company Name:	
Patient DOB:		Patient Job Title:	
Contact Date:		Authorized By:	
Contact Time:		Company Phone:	
Scheduled By:		Appt Date:	
		Appt Time:	

Services, Testing and Procedures as per the Employer Protocol:

9/12/2016

Specific Instructions:

<input type="checkbox"/>	DOT Exam - Initial	<input type="checkbox"/>	EXM - Fit for Duty	<input type="checkbox"/>	TB - PPD Placement
<input type="checkbox"/>	DOT Exam - Recert	<input type="checkbox"/>	EXM - P&S Evaluation	<input type="checkbox"/>	TB - Symptom review
<input type="checkbox"/>	Drug - BAT DOT	<input type="checkbox"/>	EXM - Physical Basic	<input type="checkbox"/>	TB - Xray Clearance
<input type="checkbox"/>	Drug - BAT NON-DOT	<input type="checkbox"/>	EXM - Physical Extended	<input type="checkbox"/>	Test - Audio
<input type="checkbox"/>	Drug - Collection Only	<input type="checkbox"/>	EXM - Post Exposure	<input type="checkbox"/>	Test - EKG
<input type="checkbox"/>	Drug - DOT 5 Panel	<input type="checkbox"/>	EXM - Pre-OP	<input type="checkbox"/>	Test - Ishihara
<input type="checkbox"/>	Drug - Hair Collection	<input type="checkbox"/>	EXM - Return to Work	<input type="checkbox"/>	Test - N95 Mask Fit
<input type="checkbox"/>	Drug - NONDOT 10 panel	<input type="checkbox"/>	EXM - sports/school	<input type="checkbox"/>	Test - PFT Spirometry
<input type="checkbox"/>	Drug - NONDOT 5 panel	<input type="checkbox"/>	Lab - Cholinesterase RBC/Plasma	<input type="checkbox"/>	Test - Stress Test
<input type="checkbox"/>	Drug - NONDOT Quick 10	<input type="checkbox"/>	Lab - Lab Urinalysis	<input type="checkbox"/>	Test - Titmas Vision
<input type="checkbox"/>	Drug - NONDOT Quick 5	<input type="checkbox"/>	Lab - Lead/Zinc	<input type="checkbox"/>	Vaccine - Flu (Fluarix)
<input type="checkbox"/>	eScreen Chest Xray 1 view	<input type="checkbox"/>	lab - QuantIFERON	<input type="checkbox"/>	Vaccine - Flu (Fluzone)
<input type="checkbox"/>	eScreen DOT Physical	<input type="checkbox"/>	Lab - RPR	<input type="checkbox"/>	Vaccine - Hep A
<input type="checkbox"/>	eScreen DOT UDS Collection	<input type="checkbox"/>	Lab - titer - Hep A	<input type="checkbox"/>	Vaccine - Hep B
<input type="checkbox"/>	eScreen eCup PASSPORT Billed to eScreen ONLY	<input type="checkbox"/>	Lab - titer - Hep B	<input type="checkbox"/>	Vaccine - MMR
<input type="checkbox"/>		<input type="checkbox"/>	Lab - titer - Hep C	<input type="checkbox"/>	Vaccine - Tdap
<input type="checkbox"/>		<input type="checkbox"/>	Lab - titer - MMR	<input type="checkbox"/>	Vaccine - Varicella
<input type="checkbox"/>	EScreen eCup NON-PASSPORT Billed to the EMPLOYER	<input type="checkbox"/>	Lab - titer - Varicella	<input type="checkbox"/>	X-Ray - Chest 1 View
<input type="checkbox"/>		<input type="checkbox"/>	Lab - UA Dip	<input type="checkbox"/>	X-Ray - Chest 2 Views
<input type="checkbox"/>	eScreen Hep B Vaccine	<input type="checkbox"/>	Lab - UA Microscopic	<input type="checkbox"/>	X-Ray - Lumbar Limited
<input type="checkbox"/>	eScreen Non-DOT Physical	<input type="checkbox"/>	Lab -	<input type="checkbox"/>	X-Ray - TB Chest 1 View
<input type="checkbox"/>	eScreen Non-DOT UDS Collection	NEW WORK INJURY WITH DRUG SCREEN – 1 REGISTRATION WITH 2 APPOINTMENTS <input type="checkbox"/> Scheduled New WC Visit – WC Billing <input type="checkbox"/> Scheduled Substance Abuse Visit – Confirm Employer Billing and enter insurance <input type="checkbox"/> EMPLOYER SERVICE LABS – Schedule separate appointment “Lab Work”			
<input type="checkbox"/>	eScreen OSHA Respiratory Physical				
<input type="checkbox"/>	eScreen PPD				
<input type="checkbox"/>	eScreen Hair Collection				
<input type="checkbox"/>		<input type="checkbox"/>			
<input type="checkbox"/>	EXM – Physical Ability Testing Time: <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 60	<input type="checkbox"/>	QUICK Urine Drug Screen		
<input type="checkbox"/>		<input type="checkbox"/>	Lot:	Exp:	Temp:

NOTES:

Reason for testing: Pre-Employment Post Accident Random Reasonable Suspicion Return to duty Follow up

Entry by:		Entry Time:		Treating MA:		Room:	
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Clinic use: Ht _____ Wt _____ BP _____ Pulse _____ O2 _____ RR _____ Temp _____ Pain _____ MA _____ Urinalysis: Leuk ___ Nit ___ Urobili ___ Protein _____ pH _____ Blood ___ Spec Grav ___ Ketone ___ Bili ___ Gluc ___ Distance Uncorrected: R 20/ ___ L 20/ ___ Near Uncorrected: R 20/ ___ L 20/ ___ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Distance Corrected: R 20/ ___ L 20/ ___ Near Corrected: R 20/ ___ L 20/ ___ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Ishihara: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Visual Fields: _____ degrees Right _____ degrees Left
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CHECK IN: [_____] READY MA: [_____] VITALS: [_____] READY DOC: [_____] CHECK OUT: [_____]