Welcome to the ACCESS OMNICARE – NEW PRIVATE PATIENT

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: [ ]

access omnicare
Inspiring health & wellness

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

DO YOU HAVE ANY OF THE NATIONS MOST COMMON MEDICAL CONDITIONS							
YES	**NO**	**Date/Year Diagnosed**	**PAST MEDICAL HISTORY**	**Date/Year Diagnosed**	**PAST MEDICAL HISTORY**	**YES**	**NO**
			Hypertension – Elevated Blood Pressure		Lung Disease		
			High Cholesterol or Lipids		Hypothyroidism		
			Diabetes		Vision Problems		
			Back Pain		Arthritis		
			Anxiety		Fibromyalgia		
			Obesity		Fatigue and/or Malaise		
			Allergies to the environment		Depression		
			Heartburn or Reflux Esophagitis		Asthma		
			Abuse or Domestic Violence		COPD		
			ADHD		Coronary Artery Disease – Heart		
			AIDS or HIV		Developmental or Behavioral Disorders		
			Anemia		Diverticulitis		
			Anesthesia Complications		Ear or Hearing Problems		
			Autism Spectrum Disorder		Eating Disorder		
			Bipolar Disorder		Eczema		
			Birth Defects or Inherited Disease		Endometriosis		
			Bladder or Kidney Problems		GI Problems		
			Blood Disease		Gout		
			Blood Transfusion		Headaches		
			Breast Cancer		Heart Attack		
			Cancer		Heart Problems		
			Chicken Pox		Hepatitis		
			Congestive Heart Failure (CHF)		Hospitalizations		
			Constipation		Hyperthyroidism		
			Infertility		Pulmonary Embolism		
			Kidney Disease		Seizures or Epilepsy		
			Kidney Stones		Skin Problems		
			Liver Disease		Stroke		
			Mental Illness		Thrombophlebitis		
			MRSA condition or exposure		Thyroid Problems		
			Muscle, Joint, or Bone Problems		Tuberculosis		
			Osteoporosis		Varicosities		
			Ovarian Cancer		Other Medical Condition – We will discuss:		
			Polyps				
			Pre-Eclampsia				

Surgical History:

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

Further social and family history will be reviewed during intake.

Patient Name: _____

CONSENT FOR EVALUATION AND TREATMENT

Authorization for Medical Services

CONSENT AND CONFIRMATION: *Please review and sign below confirming your agreement with the practice specifics*

CONSENT FOR EVALUATION AND TREATMENT

- I hereby consent to and authorize Access Omnicare (AOC) and its affiliates, physicians and employees to perform a history, physical examination and/or medical treatment as deemed necessary. Treatment may include, without limitation, any required history, examination, medical, diagnostic or laboratory tests and medical procedures ordered by the physician(s) to be performed by the designated AOC staff. I understand I may refuse treatment at any time. I understand that certain special medical exams such as physical exams (e.g. fitness for duty, school or sports) and other services are not intended to diagnose medical conditions, determine treatment needs, or replace the medical care of my personal physician.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I understand that AOC desires that I be fully informed about how my protected health information will be used and disclosed. I understand that I may receive automated phone calls, text messages, email notifications regarding my pending appointments, testing results and clinic communications. I understand that I may adjust components of my Privacy Information through communication with the Access Omnicare Clinic.

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY AGREEMENT

- If applicable, where I have insurance coverage to pay for services rendered, I hereby authorize and assign to AOC any and all payments under the terms of my applicable insurance policies, and hereby obligate each payer to make payment directly to AOC for services rendered. If applicable, where I am treated on a private pay basis I understand I am responsible for payment of services in full. I have a right to ask for the charge amounts before electing treatment.
- If applicable, where 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, in accordance with State or Federal workers' compensation laws.
- Where applicable, I understand that I am responsible to pay for deductibles, copayments and other charges in accordance with my benefit plan and determinations made by health insurance carriers as allowed by law. Should my account be referred for collection, I understand that I may have to pay collection expenses incurred by AOC, without limitation, court costs and attorney's fees as allowed by law.

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: _____

Spouse/Parent/Guardian/Conservator signature confirming:

Print Name: _____ Signature: _____ Date: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. parts 160 and 164

I understand that Access Omnicare (AOC) desires that I be fully informed about how my protected health information will be used and disclosed. I acknowledge that I have reviewed or have been given an opportunity to review the AOC Notice of Privacy Practices Handout. I may ask for a copy of the notice or can view it electronically at http://www.accessomnicare.com. I acknowledge that I understand how my information will be used and disclosed, and give my voluntary consent to AOC to use and disclose my protected health information for reasons as allowed or required as explained in the Notice.

This authorization for release of information covers the period of healthcare in force and effect through the calendar year of signing, after which time this authorization expires. I understand I will be asked to update this authorization annually.

I authorize the release of my complete health record and participation in the electronic health information exchange (HIE) unless otherwise modified. This medical information may be used by the AOC staff to optimize safety and communication in medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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Spouse/Parent/Guardian/Conservator signature confirming:

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