SoutheastHEALTH Occupation Medicine Clinic
Patient Information Sheet

DATE ______________________

Name (First, Middle, Last): ______________________

Date of Birth: ______________________ SSN: ______________________

Mailing Address: ______________________

City, State and Zip: ______________________

Phone: ______________________ Home Cell Other

Alt Phone: ______________________ Home Cell Other

What company sent you? ______________________

Have you been out of the country in the last 30 days? Yes No

If so, where? ______________________

Have you been around anyone who has been out of the country in the last 30 days?
Yes No I don't know

If so, where? ______________________

SOUTHEAST HEALTH AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of patient (Printed) ______________________ Previous Names (if applicable) ______________________

Date of Birth ______________________ Daytime Phone Number ______________________

Send Information to: (please be specific)

Provider Name/Orginazation ______________________

Address ______________________ Phone Number ______________________

City, State, Zip ______________________ Fax Number ______________________

Information to be Released From: (please be specific)
Southeast Health- Occupational Medicine
2126 Independence
Cape Girardeau, MO 63703
Phone: 573-986-4404
Fax: 573-986-4439

Purpose of Disclosure:

[ ] Transfer of Care
[ ] Self
[ ] Specialist
[ ] Other (must complete)______________________

Information to be Disclosed:

Date of Service: ______________________

[ ] Medical Records from the last two years
[ ] Summary Health Information
[ ] Complete Designed Record Set
[ ] Billing Claim Form
[ ] Detailed Billing Statement

[ ] Other:______________________ [ ] Expiration Date (or event):______________________

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 180 days of receipt, and may be revoked at any time, provided the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re−disclosure and may no longer be protected by the HIPAA of 1996.

Signature of Patient or Representative ______________________ Relationship to Patient ______________________ Date __________

Disclosures Requiring Special Consent:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

[ ] HIV / AIDS virus
[ ] Mental Health / Psychiatric Disorders
[ ] Sexually Transmitted Diseases
[ ] Drug, Alcohol Abuse / Treatment

Signature of Patient or Representative ______________________ Relationship to Patient ______________________ Date __________

For Facility Use:
Date Received:__________________Medical Record Number:______________________Date Information Release:________________
Person/Department Sending Records:______________________

CONDITIONS OF ADMISSION

CONSENT TO TREATMENT

I consent to receive medical services ordered by my physician and other practitioners under his or her direction or in consultation with my physician(s)'s orders. I acknowledge that no guarantee has been made as to the outcome, benefits or results of the services provided. I further consent to the disposal of any and all bodily fluids or tissues obtained for examination. In the event any person involved in my care is inadvertently exposed to a biological specimen which risks the transfer of an infectious disease; I consent to a blood test for the antibodies to Hepatitis C, Hepatitis B, and the human immunodeficiency virus (HIV).
I [ ] Consent – [ ] Do not consent to the observation or participation in my care by health care students and/or medical supply personnel requested by my physician.

ASSIGNMENT OF BENEFITS

I hereby assign to Southeast Health, its hospital based physicians (Southeast Missouri Hospital Physicians, LLC., Radiology Consultants, and Pathology Associates) and all independent practitioners providing professional services to me respectively. Any benefits to which I may be entitled under policies of commercial insurance, Medicare, or Medicaid for the services provided by each of these providers.

GOVERNMENT HEALTH PROGRAMS

I certify that the informations given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim file by the hopsital. I request that payment of authorized benefits be made on my behalf. I agree that I am responsible for deductibles, coinsurance, and charges for noncovered charges.

[ ] I have completed the Medicare secondary payor questionnaire.
[ ] I have received a copy of "AN IMPORTANT MESSAGE FROM MEDICARE OR CHAMPUS/CHAMPVA."

COMMERCIAL INSURANCE PRE–CERTIFICATION

If my insurance company requires my hospital services to be certified prior to receiving them. I am responsible for notifying my insurance company. I understand that failure to obtain any required pre–certification may result in all or a portion of my charges not being covered by insurance. Patients should determine if their physicians participate in the health care plan to which claims will be submitted.

PROMISE TO PAY

I promise to pay Southeast Health, Southeast Missouri Hospital Physicians, LLC., all hospital based physicians, and all independent practitioners providing professional medical services to me their usual, customary and reasonable charges for services provided. I further agree to pay the costs of collection, including court costs and reasonbable attorneys' fees incurred by Southeast Health in the collection of this account. Accounts placed for third party collection may accrue interest at the highest rate permitted by law. I also agree to waive venue and do agree that any action filed to collect any amount due for services rendered shall be filed in Cape Girardeau County Missouri.
I consent to receiving telecommunications, including autodialed or prerecorded calls, from Southeast or third party collections agencies regarding my account by contacting any phone number I provide, including my wireless telephone number.

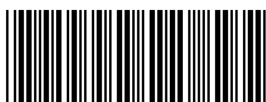
AUTHORIZATION TO RELEASES INFORMATION/REQUEST FOR PAYMENT

I authorize my holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
I authorize release of information required for the filing of any claim for payment of this account by any insurance company any employer by Southeast Health.
I authorize release of information and assign payment of all insurance benefits to the radiologists, pathologists, oncologist, and anesthesiologist. Community Counseling center, and other physicians or independent contractors providing services at Southeast Health that WILL BE BILLED SEPARATELY BY THOSE PROVIDERS.
I and my support person(patient representative) when applicable have received a copy of my Patient rights.

Signed: ______________________________ Date: ______________________
(patient)

______________________________ Relationship: ______________________
(or Authorized Person)

______________________________ Date of Service: ______________________
witness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Rev. 03/2014

SUMMARY OF NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFOMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We have summarized our Notice of Privacy Practices on this page. For a complete description of your rights and our responsibilities, please review the entire notice.

Your Rights

Your rights related to your medical information are as follows:

* The right to request restrictions on the way we use your medical information;
* The right to request and receive information from us in a different way or manner;
* The right to review your medical information;
* The right to request that we amend your medical infomation; and
* The right to know how we have used or disclosed your medical information.

We will not use or diclose your health information without your authorization, except as otherwise described in this Notice or Privacy Practices.

What We Are Required to Do

It is our responsibility to:

* Protect your medical information;
* Provide you with our Notice of Privacy Practices; and
* Abide by the terms of this Notice.

We can change our privacy practices. If we decide to change them, we will change this Notice and post the changes in our hospital [and on our website].

If you have any questions and/or would like additional information, please contact the Privacy Officer at (573) 651–5500.

ACKNOWLEDGEMENT of RECEIPT OF SOUTHEAST HEALTH'S Notice of Practices

I acknowledge that I have been provided with Southeast Health's Notice of Privacy Practices.

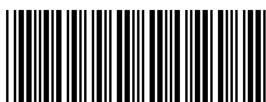
____________________________________ ____________________

Patient or Representative Date

[ ] Patient was unwilling/unable to sign acknowledgment.

Reason:____________________________________

Staff Initials:__________________ Date:____________



PLEASE PRINT

Southeast Occupational Medicine Clinic

PATIENT POST-INJURY HISTORY

NAME: ___________________________________ SSN: ______________________ DATE OF INJURY: _____________

What body part was injured?
Describe how injury/illness occurred:

Please answer every question truthfully. If you do not understand the question, ask* CLINICAL *personal.

Have you lost time from work due to illness/injury in the past 10 years? YES NO
If yes, please list the cause and length of time off.

Have you ever been treated for the same body part and/or injury? YES NO
If yes, please explain.

Have you ever made a Workers' Compensation claim or received benefits? YES NO
If yes, please explain.

Do you have any allergies, medication/chemical/environmental? YES NO
If yes, please explain.

Are you taking any medication? YES NO If yes, please list

Have you ever been hospitalized and/or had surgery (neck, back, knee, others)? YES NO
If yes, please explain.

Have you ever had any broken bones? YES NO If yes, please list:

WOMEN: Are you pregnant? YES NO Date of last menstrual period ______________________

Date of last tetanus: ____________________________

Has any of your family (mother/father/sibling) had/have cancer, diabetes, high blood pressure, thyroid problems, arthritis, heart problems, stroke? YES NO
If yes, please explain

Do you drink alcohol? YES NO If yes, how much per week?_______________________________________

Do you use any tobacco products? YES NO If yes, list type _______________________ How much? _________

If you ever smoked, when did you stop? _____________________

	Y	N		Y	N
Have you had any undesired weight loss or weight gain?			Do you have an Advance Directive?		
Do you have difficulty eating or dressing yourself?			Do you want more info. about Advance Directive?		
Do you have vision problems?					

I acknowledge that I have answered all questions completely and accurately.

Signature: ____ Date: _________________________________

Revised 11/18/15

SoutheastHEALTH Occupational Medicine Clinic
PHYSICIAN EVALUATION

PLEASE PRINT

Name: ______________________________ DOB: ______________

MEDICAL HISTORY: Please answer every question completely and accurately. If you do not understand the question, ask clinical personnel.

YES NO Have you ever had any low back injuries or trouble with your low back? ______________________________

YES NO Any previous neck or back surgery? If yes, list: ______________________________

YES NO Any previous surgery of any kind not listed above? If yes, list: ______________________________

YES NO Any serious illness or injury no listed above? If yes, list: ______________________________

YES NO Have you ever been hospitalized for mental health problems? ______________________________

YES NO Do you take any routine medications? If yes, list: ______________________________

YES NO Any allergies? If yes, list: ______________________________

YES NO Last tetanus injection? Date: ____________

SOCIAL HISTORY

YES NO Do you use tobacco or tobacco products? ____________________ How much? ____________

YES NO Do you drink alcohol? If yes, how much per week? ______________

YES NO Do you have any physical hobbies or recreational activities? ______________________________

OCCUPATIONAL HISTORY

YES NO What is your usual occupation or trade? ______________________________

YES NO Are you capable of frequently lifting 100 lbs.? If no, how much can you lift? ______________________________

YES NO Have you ever had an illness, injury or claim arising out of your employment? If yes, list: ______________________________

YES NO Have you ever been turned down for military service, insurance or employment due to your health? List: ______________________________

YES NO Any health concerns? ______________________________

YES NO Father living? If no, list age and cause of death: ______________________________

YES NO Mother living? If no, list age and cause of death: ______________________________

FEMALES ONLY

YES NO Are you pregnant? Last menstrual period: ______________

I acknowledge that I have answered all questions completely and accurately.

Signature: ______________________________ Date: ______________

OCCPC-7 REV 01/2014

HEALTH HISTORY QUESTIONNAIRE

HAVE YOU **EVER** HAD IN THE PAST OR DO YOU CURRENTLY HAVE AT THE PRESENT TIME ANY OF THE FOLLOWING?
PLEASE CHECK YES OR NO ON ALL QUESTIONS. ANSWER EVERY QUESTION ACCURATELY.

	YES	NO		YES	NO
ABDOMINAL PAIN/STOMACH PROBLEMS			HEAD INJURY		
ABNORMAL BLOOD STUDIES/ BLEEDING DISORDER			HEADACHES/ MIGRAINES		
ANEMIA/FATIGUE			HEARING DIFFICULTY		
ANXIETY/DEPRESSION/MENTAL ILLNESS			HEART ATTACK/ HEART FAILURE		
ARM OR LEG WEAKNESS			HEART BURN/ INDIGESTION		
ARTHRITIS, SWOLLEN PAINFUL BONES/JOINTS			HEART MURMUR/ IRREGULAR HEARTBEAT		
ATOPIC DERMATITIS			HEPATITIS/ JAUNDICE		
ATTENTION DEFICIT DISORDER/ ADHD			HERNIA		
ATTEMPTED HARM TO YOURSELF OR OTHERS			HERPES/ SHINGLES		
BACK TROUBLE/PAIN/STRAIN/INJURY			HIV/ AIDS OR OTHER COMMUNICABLE DISEASES		
BLOOD IN URINE OR STOOL			HIVES/ RASH/ SKIN SORES/ PSORIASIS		
BLOOD PRESSURE, HIGH/LOW			INSOMNIA		
BONES/JOINT DEFORMATION OR STIFFNESS			KIDNEY/ URINARY/ BLADDER PROBLEMS		
BONES- BROKEN			LIVER PROBLEMS		
BRONCHITIS/ ASTHMA/ WHEEZING			LOOSE STOOLS/ DIARRHEA		
CANCER			LUNG PROBLMES		
CHEST PAIN/ DISCOMFORT/ TIGHTNESS			MEMORY LOSS/ FORGETFULNESS		
CHRONIC FATIGUE SYNDROME			NAUSEA/ VOMITING/ MOTION SICKNESS		
COLDS/ FREQUENT INFECTIONS			NECK PAIN OR INJURY		
CYSTS/ LUMPS/ TUMORS			NERVOUSNESS/ STRESS/ PSYCHOSIS		
POSITIVE PPD/ TB TREATMENT			NUMBNESS OR TINGLING IN ANY PART OF BODY		
COUGH- PRODUCTIVE/ UNPRODUCTIVE			PANCREATIC DISEASE		
DIABETES- HIGH/ LOW BLOOD SUGAR			PARALYSIS		
DISC- RUPTURED/ BULGING			PEPTIC ULCER		
DIZZINESS/ BLACKOUTS/ FAINTING			PNEUMONIA		
DRUG/ALCOHOL ABUSE			POOR VISION- GLAUCOMA, WEAR GLASSES OR CONTACTS		
EMPHYSEMA/ CHRONIC COUGH/ COPD			PROSTATE PROBLEMS		
EPILEPSY/ SEIZURES/ TREMORS			SHORTNESS OF BREATH WITH EXERTION		
EXPOSURE TO HAZARDOUS MATERIALS			SHORTNESS OF BREATH WITH WAKENING		
EYE, EAR, NOSE, OR THROAT PROBLEMS			SLEEP APNEA/ CPAP USE		
FIBROMYALGIA			STROKE		
FINGER/ HAND/ WRIST/ ARM/ SHOULDER PROBLEMS			SWELLING AROUND EYES/ FACE		
FOOT/ ANKLE/ KNEE/ LEG/ HIP PROBLEMS			THYROID PROBLEMS		
GALLBLADDER PROBLEMS			URINATION- PAIN, FREQUENCY, BURNING		
HAY FEVER/ ALLERGIES/ SINUS PROBLEMS			WEIGHT LOSS OR GAIN		
			WORK RESTRICTIONS OR LIMITATIONS DUE TO HEALTH		

I acknowledge that I have answered all questions accurately.

Signature: ____ Date: ____________________

Southeast HEALTH

SoutheastHEALTH Occupation Medicine Clinic
Medications

Patient Name: ____

Pharmacy: _____________________________________ Pharmacy Phone: ____________________

Drug Allergies:

Medication	Dosage	Frequency