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

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

Southeast HEALTH

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

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Anyone required to wear a respirator mask at work must complete a Medical Evaluation Questionnaire and/or be fit tested (OSHA Regulations Standard- 29 CFR).

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Can you read? (circle one): YES NO

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. Your name: _____
3. Your age (to the nearest year): _____
4. Sex (circle one): Male Female
5. Your height: _____ ft. _____ in.
6. Your weight:_____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care provider who reviews this questionnaire (include area code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): YES NO
11. Check they type of respirator you will use (you can check more than one category):
    - ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
    - ☐ Other type (for example, half or full face piece, powered-air purifying, or SCBA).
12. Have you ever worn a respirator (circle one): YES NO
    If yes, what type(s): _____

Part A. Section 2. (Mandatory) Please circle **YES or NO individually for each question**

1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?	YES	NO
2. Have you ***ever had*** any of the following conditions?		
a. Seizures (fits)	YES	NO
b. Diabetes (blood sugar disease)	YES	NO
c. Allergic reactions that interfere with your breathing	YES	NO
d. Claustrophobia (fear of closed-in spaces)	YES	NO
e. Trouble smelling odors	YES	NO
If yes, please explain:		

3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestos	YES	NO
b. Asthma	YES	NO
c. Chronic bronchitis	YES	NO
d. Emphysema	YES	NO
e. Pneumonia	YES	NO
f. Tuberculosis	YES	NO
g. Silicosis	YES	NO
h. Pneumothorax (collapsed lung)	YES	NO
i. Lung cancer	YES	NO
j. Broken ribs	YES	NO
k. Any chest injuries or surgeries	YES	NO
l. Any other lung problem that you've been told about	YES	NO
If yes, please explain:		
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	YES	NO
b. Shortness of breath when walking fast on ground level or walking up a slight hill or incline	YES	NO
c. Shortness of breath when walking with other people at an ordinary pace on level ground	YES	NO
d. Have to stop for breath when walking at your own pace on ground level	YES	NO
e. Shortness of breath when washing or dressing yourself	YES	NO
f. Shortness of breath that interferes with your job	YES	NO
g. Coughing that produces phlegm (thick sputum)	YES	NO
h. Coughing that wakes you early in the morning	YES	NO
i. Coughing that occurs mostly when you are lying down	YES	NO
j. Coughing up blood in the last month	YES	NO
k. Wheezing	YES	NO
l. Wheezing that interferes with your job	YES	NO
m. Chest pain when you breathe deeply	YES	NO
n. Any other symptoms that you think may be related to lung problems	YES	NO
If yes, please explain:		
5. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Heart attack	YES	NO
b. Stroke	YES	NO
c. Angina	YES	NO
d. Heart failure	YES	NO
e. Swelling in your legs or feet (not caused by walking)	YES	NO
f. Heart arrhythmia	YES	NO
g. High blood pressure	YES	NO
h. Any other heart problems that you've been told about	YES	NO
If yes, please explain:		
6. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Frequent pain or tightness in your chest	YES	NO
b. Pain or tightness in your chest during physical activity	YES	NO
c. Pain or tightness in your chest that interferes with your job	YES	NO

d. In the past two years, have you noticed your heart skipping or missing a beat	YES	NO
e. Heartburn or indigestion that is not related to eating	YES	NO
f. Any other symptoms that you think may be related to heart or circulation problems	YES	NO
If yes, please explain:		
7. Do you ***currently*** take medication for any of the following problems?	YES	NO
a. Breathing or lung problems	YES	NO
b. Heart trouble	YES	NO
c. Blood pressure	YES	NO
d. Seizures	YES	NO
If yes, please explain:		
8. If you've used a respirator, have you ***ever had*** any of the following problems (if you've NEVER used a respirator go on to question 9)?	YES	NO
a. Eye irritation	YES	NO
b. Skin allergies or rashes	YES	NO
c. Anxiety	YES	NO
d. General weakness or fatigue	YES	NO
e. Any other problem that interferes with your use of a respirator	YES	NO
If yes, please explain:		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	YES	NO
If yes, please explain:		

Part B. Section 1.

Questions 10-15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to wear other types of respirators, answering these questions is voluntary.

10. Have you ***ever*** lost vision in either eye (temporarily or permanently)?	YES	NO
11. Do you ***currently*** have any of the following vision problems?		
a. Wear contact lenses	YES	NO
b. Wear glasses	YES	NO
c. Color blind	YES	NO
d. Any other eye or vision problem	YES	NO
If yes, please explain:		
12. Have you ***ever had*** an injury to your ears, including a broken ear drum?	YES	NO
If yes, please explain:		
13. Do you ***currently*** have any of the following hearing problems?		
a. Difficulty hearing	YES	NO
b. Wearing a hearing aid	YES	NO

c. Any other hearing or ear problems	YES	NO
If yes, please explain:		
14. Have you ***ever had*** a back injury?	YES	NO
If yes, please explain:		
15. Do you ***currently*** have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet	YES	NO
b. Back pain	YES	NO
c. Difficulty fully moving your arms and legs	YES	NO
d. Pain or stiffness when you lean forward or backward at the waist	YES	NO
e. Difficulty fully moving your head up or down	YES	NO
f. Difficulty fully moving your head side to side	YES	NO
g. Difficulty bending at your knees	YES	NO
h. Difficulty squatting to the ground	YES	NO
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	YES	NO
j. Any other muscle or skeletal problem that interferes with using a respirator	YES	NO
If yes, please explain:		

Part B. Section 2.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?	YES	NO
If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?		
2. At work or at home, have you ***ever*** been exposed to hazardous solvents, hazardous airborne chemicals (gases, fumes, dust) or have you come into skin contact with hazardous chemicals?	YES	NO
If yes, please explain:		
3. Have you ***ever*** worked with any of the materials, or under any of the conditions, listed below?		
a. Asbestos	YES	NO
b. Silica (in sandblasting)	YES	NO
c. Tungsten/cobalt (grinding or welding this material)	YES	NO
d. Beryllium	YES	NO
e. Aluminum	YES	NO
f. Coal (mining)	YES	NO
g. Iron	YES	NO
h. Tin	YES	NO
i. Dusty environments	YES	NO
j. Any other hazardous exposures	YES	NO
If yes, please explain:		

4. List any second jobs or side businesses you have:		
5. List your previous occupations:		
6. List your current and previous hobbies:		
7. Have you been in the military services?	YES	NO
If yes, were you exposed to biological or chemical agents (in training or combat)	YES	NO
8. Have you ***ever*** worked on a HAZMAT team?	YES	NO
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier, are you taking any other medication (including over-the-counter) for any reason?	YES	NO
If yes, please list the medications:		
10. Will you be using any of the following items with your respirator?		
a. HEPA Filters	YES	NO
b. Canisters	YES	NO
c. Cartridges	YES	NO
11. How often are you expected to use the respirator?		
a. Escape only (no rescue)	YES	NO
b. Emergency rescue only	YES	NO
c. Less than 5 hours per week	YES	NO
d. Less than 2 hours per day	YES	NO
e. 2-4 hours per day	YES	NO
f. Over 4 hours per day	YES	NO
12. During the period you are using your respirator, is your work effort:		
a. Light (sitting while writing, performing light assembly work, standing and operating drill press or controlling machines)	YES	NO
If yes, how long does this period last during the average shift: hrs. mins.		
b. Moderate (sitting while nailing, driving truck in urban traffic, standing while drilling, transferring a moderate load, walking on level surface)	YES	NO
If yes, how long does this period last during the average shift: hrs. mins.		
c. Heavy (lifting a heavy load, working on loading dock, shoveling, walking up an incline, climbing stairs with heavy load)	YES	NO
If yes, how long does this period last during the average shift: hrs. mins.		
13. Will you be wearing protective clothing and/or equipment when you're using your respirator?	YES	NO
If yes, describe the protective clothing and equipment:		
14. Will you be working under hot conditions (temperature exceeding 77° F)?	YES	NO
15. Will you be working under humid conditions?	YES	NO
16. Describe the work you'll be doing while you're using your respirator:		

17. Describe any special or hazardous conditions you might encounter when you're using your respirator (confined spaces, life-threatening gases):
18. If available, please provide the names of any toxic substances you will be exposed to when you're using your respirator:
19. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (security, rescue):

Employee Signature: _____ Date: _____

Sent for Fit Testing: YES NO Fit Testing (see attached): PASS FAIL

- ☐ Employee is medically approved to use the respirator(s) designated through fit test without restrictions.
- ☐ Employee is not medically approved to use the respirator(s).
- ☐ Employee is medically approved with listed limitations: _____

Health care professional review and recommendations: _____

_____

_____

Health Care Provider signature: _____ Date: _____