CORE COMPREHENSIVE OCCUPATIONAL RESOURCES

Patient Registration - Consent Form

Please fill-out form completely. See the back page of this form for Notice of Privacy Practices.

Please Print or Submit Electronically

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: Male: ○ Female: ○

Home Address: _____ Emergency Contact: _____

City, State, ZIP: _____ Emergency Phone: _____

Email Address: _____ Relationship: _____

Home Phone: _____ Employer: _____

Primary Care Physician: _____ Work Phone: _____

Reason for Visit:

INFORMATION *(MUST be completed for Comprehensive Occupational Resources to perform services)*

I hereby voluntarily consent to evaluation, medical care, obtaining specimens, and to such treatment, as requested by my employer or prospective employer, as is necessary in the judgment of the Physician in attendance. I understand and agree that the results of this test will be disclosed to my Company's representative and/or Medical Review Officer and hereby release CORE LLC, and any employees and/or agents thereof from any and all claims or causes of actions resulting from the disclosure of these results. I understand that the examination and/or medical treatment I will receive is not intended to replace medical care by my personal physician.

Pursuant to LSA R.S. 23:1208.1, I understand that the failure to answer truthfully any questions related to my health history or current condition may result in a denial of any right I or my dependent(s) may have to Workers' Compensation benefits. Including medical treatment and expenses.

I have reviewed the Comprehensive Occupational Resources LLC. Notice of Privacy Practices and have read the terms and conditions on the back of this form.

SIGNED: _____ **DATE:** 11/01/2012

COMPLETE THIS SECTION ONLY IF UNDER THE AGE OF 18

Parent/Guardian Name: _____ Parent/Guardian Employer: _____

Please review Privacy Practices. This form continues on page 3 below.

CORE HEALTH NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION: The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization, and we need this record to provide you with quality care and to comply with certain legal requirements. This notice will describe the ways we may use and share this information.

INSURANCE POLICY: Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with accurate policy information. You are responsible for all deductibles not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We **do not participate** with any Medical Assistance policies. We **do not** bill insurance carriers for Travel Immunizations.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize **CORE LLC** to release any medical information and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the provider deems it necessary in order to ensure the best medical care on my behalf. **I** further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization without a further authorization signed by me for release of the information.

USE AND DISCLOSURE: Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.

Reminders/Notifications. Our staff will use your health information to send you follow-up care, referral or appointment reminders. We may also send you information describing changes occurring at **CORE LLC** such as, address changes, new locations or changes in business hours.

Treatment Information. Your health information may be used to send you information that you may find interesting on the treatment and management of you medical condition. We may also send you information describing other health-related products and services that may be of interest to you.

Payment. We may use and disclose your medical information for payment purposes. We may need to give your health insurance plan information so that your health plan will pay us or repay you for services.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of COREHEALTH. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting accreditation, certificates, licenses and credentials we need to serve you.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Workers Compensation. We may disclose health information to workers compensation or other similar programs.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information,
- the right to receive confidential communication regarding your medical condition and treatment,
- the right to inspect and copy your protected health information,
- the right to an accounting of how and to whom your protected health information has been disclosed,
- the right to receive a printed copy of this notice

COREHEALTH DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY POLICIES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMMENTS & COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices you can do so by sending a letter outlining your concerns to this office, attention: Privacy Official : Major Mittendorf – mmittendorf@coreoccupational.com 225-756-2673 10059 Reiger Road Baton Rouge, LA 70809. If you believe that your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the address listed above. You will not be penalized or otherwise retaliated against for filing a complaint.

FOR ADDITIONAL INFORMATION: Please inquire at the reception desk for a copy of the CORE LLC Privacy Standards.

EFFECTIVE DATE: January 1, 2011

COMPREHENSIVE OCCUPATIONAL RESOURCES

ASBESTOS INITIAL MEDICAL QUESTIONNAIRE

1. NAME _____

2. SOCIAL SECURITY NUMBER # _____

3. CLOCK NUMBER _____

4. PRESENT OCCUPATION _____

5. PLANT _____

6. ADDRESS _____

_____

8. TELEPHONE NUMBER _____

9. INTERVIEWER _____

10. DATE 11/01/2012

11. Date of Birth _____
Month Day Year

12. Place of Birth _____

13. Sex 1. Male ___
2. Female ___

14. What is your marital status? 1. Single ☐ 2. Married ☐ 3. Widowed ☐
4. Separated / Divorced ☐

15. Race 1. White ☐ 4. Hispanic ☐
2. Black ☐ 5. Indian ☐
3. Asian ☐ 6. Other ☐

16. What is the highest grade completed in school? _____

(For example 12 years is completion of high school)

COMPREHENSIVE OCCUPATIONAL RESOURCES

OCCUPATIONAL HISTORY

17A. Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes ☐ 2. No ☐

IF YES TO 17A:

B. Have you ever worked for a year or more in any dusty job? 1. Yes ☐ 2. No ☐ 3. Does Not Apply ☐

Specify job/industry _____ Total Years Worked _____

Was dust exposure: 1. Mild ☐ 2. Moderate ☐ 3. Severe ☐

C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ☐ 2. No ☐

Specify job/industry _____ Total Years Worked ___

Was exposure : 1. Mild ☐ 2. Moderate ☐ 3. Severe ☐

D. What has been your usual occupation or job -- the one you have worked at the longest?

1. Job occupation _____

2. Number of years employed in this occupation _____

3. Position/job title _____

4. Business, field or industry _____
(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:	YES	NO
E. In a mine?	☐	☐
F. In a quarry?	☐	☐
G. In a foundry?	☐	☐
H. In a pottery?	☐	☐
I. In a cotton, flax or hemp mill?	☐	☐
J. With asbestos?	☐	☐

18. PAST MEDICAL HISTORY

	YES	NO
A. Do you consider yourself to be in good health?	☐	☐

If "NO" state reason _____

B. Have you any defect of vision? ☐ ☐

If "YES" state nature of defect _____

	YES	NO
C. Have you any hearing defect?	☐	☐

If "YES" state nature of defect _____

D. Are you suffering from or have you ever suffered from:

	YES	NO
a. Epilepsy (or fits, seizures, convulsions)?	☐	☐
b. Rheumatic fever?	☐	☐
c. Kidney disease?	☐	☐
d. Bladder disease?	☐	☐
e. Diabetes?	☐	☐
f. Jaundice?	☐	☐

19. CHEST COLDS AND CHEST ILLNESSES

19A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time)
1. Yes ☐ 2. No ☐ 3. Don't get colds ☐

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ☐ 2. No ☐

IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses?
1. Yes ☐ 2. No ☐ 3. Does Not Apply ☐

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
Number of illnesses ___ No such illnesses ☐

21. Did you have any lung trouble before the age of 16?
1. Yes ☐ 2. No ☐

22. Have you ever had any of the following?

1A. Attacks of bronchitis? 1. Yes ☐ 2. No ☐

IF YES TO 1A:

B. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. At what age was your first attack? Age in Years ___
Does Not Apply ☐

2A. Pneumonia (include bronchopneumonia)? 1. Yes ☐ 2. No ☐

IF YES TO 2A:
B. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. At what age did you first have it? Age in Years ___
Does Not Apply ☐

3A. Hay Fever? 1. Yes ☐ 2. No ☐
IF YES TO 3A:
B. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. At what age did it start? Age in Years ___
Does Not Apply ☐

23A. Have you ever had chronic bronchitis? 1. Yes ☐ 2. No ☐

IF YES TO 23A:
B. Do you still have it? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

D. At what age did it start? Age in Years ___
Does Not Apply ☐

24A. Have you ever had emphysema? 1. Yes ☐ 2. No ☐
IF YES TO 24A:
B. Do you still have it? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

D. At what age did it start? Age in Years ___
Does Not Apply ☐

25A. Have you ever had asthma? 1. Yes ☐ 2. No ☐
IF YES TO 25A:

B. Do you still have it? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

C. Was it confirmed by a doctor? 1. Yes ☐ 2. No ☐
3. Does Not Apply ☐

D. At what age did it start? Age in Years ___

Does Not Apply ☐

E. If you no longer have it, at what age did it stop?

Age stopped ___

Does Not Apply ☐

26. Have you ever had:

A. Any other chest illness? 1. Yes ☐ 2. No ☐

If yes, please specify _____

B. Any chest operations? 1. Yes ☐ 2. No ☐

If yes, please specify _____

C. Any chest injuries? 1. Yes ☐ 2. No ☐

If yes, please specify _____

27A. Has a doctor ever told you that you had heart trouble?

1. Yes ☐ 2. No ☐

IF YES TO 27A:

B. Have you ever had treatment for heart trouble in the past 10 years?

1. Yes ☐ 2. No ☐

3. Does Not Apply ☐

28A. Has a doctor told you that you had high blood pressure?

1. Yes ☐ 2. No ☐

IF YES TO 28A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?

1. Yes ☐ 2. No ☐

3. Does Not Apply ☐

29. When did you last have your chest X-rayed?

(Year) _____

30. Where did you last have your chest X-rayed (if known)?

_____

What was the outcome? _____

FAMILY HISTORY

31. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

FATHER	MOTHER
1. Yes ☐ 2. No ☐ 3. Don't Know ☐	1. Yes ☐ 2. No ☐ 3. Don't Know ☐

COMPREHENSIVE OCCUPATIONAL RESOURCES

	FATHER	MOTHER
A. Chronic Bronchitis?	☐	☐
B. Emphysema?	☐	☐
C. Asthma?	☐	☐
D. Lung cancer?	☐	☐

E. Other chest conditions?

_____ _____

F. Is parent currently alive?

Yes ☐ No ☐ Yes ☐ No ☐

G. Please Specify:

Age if Living ___ Age if Living ___
Age at Death ___ Age at Death ___
Don't Know ☐ Don't Know ☐

H. Please specify cause of death

_____ _____

COUGH

32A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) (If no, skip to question 32C.)

1. Yes ☐ 2. No ☐

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

1. Yes ☐ 2. No ☐

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes ☐ 2. No ☐

D. Do you usually cough at all during the rest of the day or at night?

1. Yes ☐ 2. No ☐

IF YES TO ANY OF ABOVE (32A, B, C, OR D,), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes ☐ 2. No ☐
3. Does not apply ☐

F. For how many years have you had the cough? ___ Number of years ___
Does not apply ☐

33A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 33C)

1. Yes ☐ 2. No ☐

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes ☐ 2. No ☐

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. Yes ☐ 2. No ☐

D. Do you usually bring up phlegm at all on during the rest of the day or at night?

1. Yes ☐ 2. No ☐

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. Yes ☐ 2. No ☐
3. Does not apply ☐

F. For how many years have you had trouble with phlegm?

Number of years ___
Does not apply ☐

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?
*(For persons who usually have cough and/or phlegm)

1. Yes ☐ 2. No ☐

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of years ___
Does not apply ☐

WHEEZING

35A. Does your chest ever sound wheezy or whistling

1. When you have a cold? 1. Yes ☐ 2. No ☐

2. Occasionally apart from colds? 1. Yes ☐ 2. No ☐

3. Most days or nights? 1. Yes ☐ 2. No ☐

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

Number of years ___
Does not apply ☐

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes ☐ 2. No ☐

IF YES TO 36A

B. How old were you when you had your first such attack?

Age in years ___

Does not apply ☐

C. Have you had 2 or more such episodes?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

D. Have you ever required medicine or treatment fr the(se) attack(s)?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s) _____

_____

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes ☐ 2. No ☐

IF YES TO 38A

B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes ☐ 2. No ☐

3. Does not apply ☐

TOBACCO SMOKING

39A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes ☐ 2. No ☐

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes ☐ 2. No ☐
3. Does not apply ☐

C. How old were you when you first started regular cigarette smoking?

Age in years ___
Does not apply ☐

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped ___
Check if still smoking ☐
Does not apply ☐

E. How many cigarettes do you smoke per day now?

Cigarettes per day ___
Does not apply ☐

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day ___
Does not apply ☐

G. Do or did you inhale the cigarette smoke?

1. Does not apply ☐
2. Not at all ☐
3. Slightly ☐
4. Moderately ☐
5. Deeply ☐

40A. Have you ever smoked a pipe regularly?
(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes ☐ 2. No ☐

IF YES TO 40A:
FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly?

Age ___

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped ___
Check if still smoking pipe ☐
Does not apply ☐

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

oz. per week ___

(a standard pouch of tobacco contains 1 1/2 oz.)

Does not apply ☐

D. How much pipe tobacco are you smoking now?

oz. per week ___

Not currently smoking a pipe ☐

E. Do you or did you inhale the pipe smoke?

1. Never smoked ☐
2. Not at all ☐
3. Slightly ☐
4. Moderately ☐
5. Deeply ☐

41A. Have you ever smoked cigars regularly?

1. Yes ☐ 2. No ☐

(Yes means more than 1 cigar a week for a year)

IF YES TO 41A

FOR PERSONS WHO HAVE EVER SMOKED A CIGARS

B. 1. How old were you when you started smoking cigars regularly? Age ___

2. If you have stopped smoking cigars completely, how old were you stopped Age stopped ___

Check if still you stopped smoking cigars ☐

Does not apply ☐

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week ___

Does not apply ☐

D. How many cigars are you smoking per week now? Cigars per week ___

Check if not smoking cigars currently ☐

E. Do or did you inhale the cigar smoke?

1. Never smoked ☐
2. Not at all ☐
3. Slightly ☐
4. Moderately ☐
5. Deeply ☐

Signature _____ Date 11/01/2012

Reset Form Submit Form