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

Self-Administered Medical Surveillance Questionnaire

Hexavalent Chromium (Cr(VI))

Name:	Date: 11/01/2012	Social Security Number:	
Date of Birth:	Age:	Sex:	Race:
Present Occupation:			
Address and phone number:			
Personal physician:			

OCCUPATIONAL HISTORY

Have you ever worked in any of these industries?

- ☐ Chemical Plant
- ☐ Chemical Laboratory
- ☐ Coke Oven
- ☐ Construction
- ☐ Cotton, Flax or Hemp Mill
- ☐ Electronics Plant
- ☐ Farm
- ☐ Foundry
- ☐ Hazardous Waste Industry
- ☐ Hospital
- ☐ Lumber Mill
- ☐ Metal Production
- ☐ Mining
- ☐ Nuclear Industry
- ☐ Paper Mill
- ☐ Pharmaceutical Industry
- ☐ Plastic Production
- ☐ Pottery Mill
- ☐ Refinery
- ☐ Rubber Processing Plant
- ☐ Sand Pit or Quarry
- ☐ Service Station
- ☐ Shipyard
- ☐ Smelter
- ☐ Waste Industry

Have you ever worked with or been exposed to?

- ☐ Aldrin
- ☐ Arsenic
- ☐ Asbestos
- ☐ Benzene
- ☐ Benzidine
- ☐ Beryllium
- ☐ Bis Chlormethyl ether
- ☐ Cadmium
- ☐ Carbon Disulfide
- ☐ Chlorine
- ☐ Clordane
- ☐ Ionizing Radiation
- ☐ Bone Marrow Toxins
- ☐ Chloroform
- ☐ Chloroprene
- ☐ Chromates
- ☐ Chromic Acid Mist
- ☐ Cutting Oils
- ☐ DDT
- ☐ Dieldrin
- ☐ Dioxin
- ☐ Dust, Coal
- ☐ Dust, Sandblasting
- ☐ Dust, Other
- ☐ Epoxy Resins
- ☐ Ethylene Dibromide
- ☐ Ethylene Dichloride
- ☐ Ethylene Oxide
- ☐ Extreme Hot or Cold
- ☐ Heptachlor
- ☐ Hexachlorobenzene
- ☐ Hexavalent Chrome
- ☐ Isocyanates (TDI, MDI)
- ☐ Lead
- ☐ Loud or Continuous Noise
- ☐ Mercury
- ☐ Methylene Chloride
- ☐ Microwaves, Lasers
- ☐ Nickel
- ☐ PCB's
- ☐ Pesticides, Herbicides
- ☐ Phenols
- ☐ Phosgene
- ☐ Plastics
- ☐ Radioactive Materials
- ☐ Roofing Materials
- ☐ Rubber
- ☐ Silica
- ☐ Solvents/Degreasers
- ☐ Soots and Tars
- ☐ Spray Painting
- ☐ Perchloroethylene
- ☐ Vinyl Chloride

Explain all "Yes" answers in this place (i.e. dates, illnesses, treatment, etc.):

_____

_____

_____

_____

_____

_____

Do you have any of the following hobbies?

- ☐ Furniture Refinishing
- ☐ Spray Painting
- ☐ Paint Stripping

MEDICAL HISTORY

General

☐Yes ☐No

Do you or have you ever had:

☐Persistent Thirst
☐Frequent Urination (three times or more at night)
☐Dermatitis or Irritated Skin
☐Non-Healing Wounds
☐Kidney Problems or abnormalities

Explain all yes answers in the space provided below.

_____
_____
_____

What prescriptions or non-prescription medications do you take and for what reasons?

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications, and if so, what type of reactions do you have?

Respiratory

Do you have or have you ever had any chest illnesses or diseases? ☐Yes ☐No

Explain.

_____

Do you have or have you ever had any of the following? ☐Yes ☐No

☐Asthma
☐Bronchitis
☐Asbestosis
☐Shortness of breath
☐Tuberculosis
☐Silicosis
☐Lung cancer
☐Byssinosis
☐Pulmonary Fibrosis
☐Emphysema
☐Wheezing
☐Pneumonia
☐Pneumothorax
☐Nasal septum perforation

Explain all yes answers in the space provided below.

_____
_____
_____

Have you ever had an abnormal chest x-ray? ☐Yes ☐No

If so, when, where, and what were the findings?

_____
_____

Have you ever had any difficulty using a respirator or breathing apparatus? ☐Yes ☐No

If yes, explain.

_____
_____

Do any chest or lung diseases run in your family? ☐Yes ☐No
If yes, explain.

_____

_____

Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐Yes ☐No
If yes, how long have you smoked? _____
What do you smoke? (please circle) ☐Cigarettes ☐Cigars ☐Pipe tobacco
How much do you smoke per day? _____

If **NO**, are you a former smoker? ☐Yes ☐No

- How long since you quit? _____
- How many years did you smoke? _____

How much did you smoke per day?

_____

_____

If you have stopped smoking completely, how old were you when you stopped? _____

On the average of the entire time you smoked, how many packs of cigarettes, cigars, or bowls of tobacco did you smoke per day? _____

Cardiovascular

Have you ever been diagnosed with any of the following: Which of the following apply to you now or did apply to you at some time in the past, even if the problem is controlled by medication? Please explain any yes answers (i.e., when problem was diagnosed, length of time on medication).

☐High Cholesterol or Triglyceride Level_____
☐Hypertension (High Blood Pressure)_____
☐Diabetes_____
☐Family History of Heart Attack, Stroke, or Blocked Arteries_____

Have you ever had chest pain? ☐Yes ☐No
If yes, answer the next five questions.
What was the quality of the pain (i.e., crushing, stabbing, squeezing)?_____
Did the pain go anywhere (i.e., into the jaw, left arm)? _____
What brought the pain out? _____
How long did it last? _____
What made the pain go away? _____
What type of treatment did you receive? _____

Have you ever had bypass surgery for blocked arteries in your heart or anywhere else? ☐Yes ☐No
If yes, explain:

_____

_____

_____

Have you ever had any other procedures done to open up a blocked artery (balloon angioplasty, carotid endarterectomy, clot dissolving drug)? ☐Yes ☐No
If yes, explain:

_____

_____

Do you have or have you ever had (explain each):
[]Heart murmur_____
[]Irregular Heartbeat_____
[]Shortness of Breath while laying flat_____
[]Congestive Heart Failure_____
[]Ankle Swelling_____
[]Recurrent Pain anywhere below the waist while walking_____

Have you ever had an EKG (electrocardiogram)? ☐Yes ☐No
When?
_____

Have you ever had an abnormal EKG? ☐Yes ☐No
If so, when, where, and what were the findings?
_____
_____

Do any heart diseases, high blood pressure, diabetes, high cholesterol, or high triglycerides run in your family?
☐Yes☐No
Explain yes answers below.
_____
_____

Hepatobiliary and Pancreas

Do you now or have you ever drunk alcoholic beverages? ☐Yes ☐No
Age started: _____
Age stopped: _____

Average numbers per week:
Beers: _____
Glasses of wine: _____
Drinks: _____
Has this changed in the last year? ☐*Yes*☐*No*
If Yes, explain: _____

Do you have or have you ever had (explain each):
☐Hepatitis (infectious, autoimmune, drug-induced, or chemical)_____
☐Jaundice_____
☐Elevated liver enzymes or elevated bilirubin_____
☐Liver disease or cancer_____
☐Stomach Trouble_____
☐Vomiting of Blood_____
☐Black Tarry Stools_____
☐Bleeding from Rectum_____

Central Nervous System

Do you have or have you ever had (explain each):
☐Headache_____
☐Dizziness_____
☐Fainting_____
☐Loss of Consciousness_____
☐Garbled Speech_____
☐Lack of Balance_____
☐Mental / Psychiatric Illness_____
☐Forgetfulness_____

Hematologic

Do you have or have you ever had (explain each):

☐Anemia_____

☐Sickle Cell Disease or Trait_____

☐Glucose-6-Phosphate Dehydrogenase Deficiency_____

☐Bleeding Tendency or Disorder_____

☐Thalassemia_____

☐Leukemia_____

If not already mentioned previously, have you ever had a reaction to sulfa drugs or to drugs used to prevent or treat malaria? ☐Yes ☐No

What was the drug? Describe the reaction:

_____

_____

Skin

In the last year have you had any of the following? Explain location (i.e. hands, arms, feet, legs, trunk, generalized, etc.).

☐Redness_____ ☐Swelling_____

☐Itching_____ ☐Dryness_____

☐Burning_____ ☐Blisters_____

☐Ulcerations_____ ☐Recurrent infection_____

PLEASE READ CAREFULLY BEFORE SIGNING.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT WITHHOLDING INFORMATION OR MAKING FALSE STATEMENTS MAY BE USED AS THE BASIS FOR DISMISSAL.

I HEREBY AUTHORIZE MY PERSONAL HEALTHCARE PROVIDER TO RELEASE ANY INFORMATION OR COPIES THEREOF ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY EMPLOYER OR HIS REPRESENTATIVE.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

_____ 11/01/2012

Signature Date

Reset Form Submit Form