



Name: \_\_\_\_\_  
 Emp No. ie: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 SS# \_\_\_\_\_  
 (employee)

phone  
#

\_\_\_\_\_

Patient Label

**MEDICAL HISTORY**

**INJURY / ILLNESS INFORMATION**

Date of Injury: \_\_\_\_\_ What part of your body is injured: \_\_\_\_\_  
 Describe how your injury / illness occurred:

Have you ever been treated for the same body part and / or injury before? Yes / No If yes, when and how?

**PATIENT PAST/ PRESENT MEDICAL INFORMATION**  
**PLEASE LIST ALL PAST HOSPITALIZATIONS / SURGERIES**

REASON	YEAR	REASON	YEAR

PLEASE LIST ALL FRACTURES / BROKEN BONES YOU HAVE HAD IN THE PAST

**WOMEN ONLY:** Pregnant?  Yes  No Date of last menstrual period:

**ALLERGIES:** If you have any allergies please list below **MEDICATIONS:** List all medications you use and why you use them (Please include all herbal, over-the-counter, and alternative medications).

None  None

**YEAR of last TETANUS VACCINE =**

**MEDICAL HISTORY (Patient/Family):** Have you or a member of your immediate family (Mother, Father, Sibling) ever been told that you have had:

	CONDITION	Yes	No	Family
1.	FATIGUE, INSOMNIA, OR WEAKNESS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	EAR, NOSE, THROAT, OR VISION PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	HEART ATTACK, CHEST PAIN, OR STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	HEART PROBLEMS, OR IRREGULAR HEART BEAT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	LUNG PROBLEMS, ASTHMA, BRONCHITIS/ PNEUMONIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	TUBERCULOSIS OR POSITIVE TB TEST	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	EMPHYSEMA OR CHRONIC COUGH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	HEAD INJURIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	ARTHRITIS/RHEUMATOID ARTHRITIS/OSTEOARTHRITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please explain all "yes" responses

### MEDICAL HISTORY

	CONDITION	Yes	No	Family
11.	ANXIETY, DEPRESSION, OR MENTAL DISORDERS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	FREQUENT HEADACHES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	DRUG, ALCOHOL ABUSE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	ULCERS, INTESTINAL, ABDOMINAL, STOMACH PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	LIVER OR SPLEEN PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	KIDNEY OR URINARY PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	EXPOSURE TO HAZARDOUS SUBSTANCES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	HERNIAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	SHOULDER, ARM OR WRIST PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	CARPAL TUNNEL SYNDROME	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	BACK OR NECK PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	LEG, ANKLE, FOOT OR KNEE PROBLEMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	DIABETES OR THYROID DISEASE OR OTHER GLAND DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	GOUT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	ANY OTHER MEDICAL CONDITION NOT LISTED ABOVE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26.	CANCER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	SEIZURES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	MUSCULAR DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PLEASE EXPLAIN ALL "YES" RESPONSES				

### SOCIAL HISTORY

List all hobbies and/or second jobs:			
Do you drink alcohol?	Yes	No	If yes, how many drinks per day:
Do you smoke or use tobacco?	Yes	No	If yes, how many packs/tins per day: <span style="float: right;">If no, when did you stop?</span>

My regular private doctor's name is: \_\_\_\_\_

I HEREBY CERTIFY THAT : I have carefully read and completed the foregoing information, and that my answers and explanations are true to the best of my knowledge and belief.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Examinee's (patient) signature Date

Office Use Only:

Xray#: \_\_\_\_\_



WORKPLACE HEALTH SERVICES

CONSENT FOR TREATMENT AND PATIENT AUTHORIZATION

Date: \_\_\_\_\_ Time \_\_\_\_\_ am pm

Authorization For Treatment: I have a condition I feel is requiring medical care. I hereby consent to the rendering of such care that may include routine diagnostic procedures, testing, x-rays and such medical treatment the provider considers to be necessary

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or warranties have been made to me as a result of treatments or examination at WorkPlace Health Services.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid by insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

I agree that in consideration of the service to be rendered to me that I am obligated to pay the account at WorkPlace Health Services in accordance with the regular rates and terms. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses incurred by WorkPlace Health Services.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

I realize that among those who attend patients at WorkPlace Health Services are medical, nursing and other health care students, who unless requested otherwise, may be present during patient care to observe and participate in my diagnosis and care as a part of their education.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center and have had the opportunity to ask questions. I certify that I understand this form and its content.

Reason for visit today \_\_\_\_\_

AUTHORIZATION:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship: Parent Court Appointed Guardian Healthcare Representative/Power of Attorney Other \_\_\_\_\_

I authorize results, referral information or questions regarding my medical care to be left on my answering machine or voice mail at the following numbers(s) \_\_\_\_\_

Patient Signature \_\_\_\_\_



Authorization for Release of Protected Health Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize, direct, and consent to the release of my medical records by or to Methodist Occupational Health Centers, Inc. as follows:

TO BE RELEASED TO/FROM:

Name \_\_\_\_\_

Insurance Carrier, Case Manager

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employers

Other Medical Provider

Other - \_\_\_\_\_

PURPOSE OF RELEASE:

For Reimbursement and Medical Care

Employer Requirements

DESCRIPTION OF THE INFORMATION TO BE RELEASED:

All Medical Records including, but not limited to:  
Doctor Notes, X-ray reports, rehabilitation notes,  
drug test results, and specialty tests.

Other \_\_\_\_\_

This authorization will also allow the issuance of verbal and written reports to the above named recipient.

I understand that I have the right to revoke this authorization at any time in writing, except to the extent that action has been taken in reliance thereon and that this consent will expire sixty (60) days from the date signed unless otherwise specified. I hereby recognize that the physician/patient privilege is waived, and direct that the requested information be given as authorized. I direct that a photocopy of this authorization shall be as valid as the original.

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

The expiration date of this authorization (consent) is 1 year from the date signed below. MOHCI and its affiliates cannot refuse treatment for not signing this authorization.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Patient)

Date: \_\_\_\_\_

\_\_\_\_\_  
(Witness)

Privacy Notice Acknowledgement Statement

I acknowledge that I have received a copy of Methodist Occupational Health Centers, Inc and Affiliates Notice of Privacy Practices and understand that I may request a version of this privacy notice at any time.

\_\_\_\_\_  
Signature of Patient (Legal Guardian, if minor)

\_\_\_\_\_  
Date