We are a fragrance-free clinic

Occupational Health Clinical Center (OHCC)

UPSTATE
MEDICAL UNIVERSITY

Serving the Adirondack, Central New York, and Southern Tier Regions of New York State

Dear Client:

Your appointment has been scheduled at the Occupational Health Clinical Center as noted below. **Prior to your appointment, please fill out and return to us the enclosed forms which are listed below.** Please mail them to:

☐ Occupational Health Clinical Center
6712 Brooklawn Parkway, Suite 204
Syracuse, NY 13211-2195
Tel (315) 432-8899 Fax (315) 431-9528

1. **PATIENT AND MEDICAL INSURANCE INFORMATION**

   Please complete these forms and be sure to include all of your private health insurance information as well as the name, address, and phone number of the Insurance Company which carries your employer's Workers' Compensation insurance. If your illness is determined to be work-related, and you choose to file for Workers' Compensation, we must have your employer's Workers' Compensation Carrier and any case numbers, if you have already filed a claim. We need this information for us to submit a bill on your behalf to the compensation insurance carrier.

2. **MEDICAL AND OCCUPATIONAL HISTORY**

   Please answer all questions regarding your past medical, family and social history to the best of your ability. These must be completed before your visit and will be reviewed with you on the day of your visit. List by year all jobs you have held since leaving school. Note the Company and what they produce or what service they provide, any exposures on the job, and any protection you may have used. The physician or nurse practitioner will review this with you on the day of your visit. Please request your employer to provide a copy of Material Safety Data Sheets (MSDS) so you can bring them to your initial visit.

3. **SYMPTOM LIST**

   Please mark any of the symptoms you have experienced in the last few months. Add any which are not listed on the form. This will also be reviewed with you on the day of your visit.

4. **RECORDS RELEASE AUTHORITY**

   MAIL THE APPROPRIATE COMPLETED FORM TO EACH PHYSICIAN and they will send us a copy of your medical record. We may not be able to complete your evaluation at the date of your initial appointment if records are not in.

A thorough evaluation of a complicated problem may take up to two hours to complete. Please plan enough time for your visit. **As a comfort to other patients, we request that you refrain from wearing any fragrances to our office.** Enclosed are directions and map showing the location of the office where your appointment is scheduled. Please refer all questions to the appropriate office above (see checked box).

Thank you for your cooperation.

APPOINTMENT DATE: ______________________ **TIME:** ______________________

OFFICE LOCATION: ______________________ **PROVIDER:** ______________________

6712 Brooklawn Parkway, Suite 204 | Syracuse, NY 13211-2195 | Ph: 315.432.8899 | Fax: 315.431.9528 | www.upstate.edu/cnyohcc

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FOR OFFICE USE ONLY

OCCUPATIONAL HEALTH CLINICAL CENTER

DATE OF VISIT: ______/______ /______ PATIENT ID #: ______________________________

☐ RE-CHK ☐ NEW PATIENT ☐ SCREENING OFFICE LOCATION: ______________________________

Please Print

PATIENT INFORMATION

First Name	Middle Name or Initial	Last Name	Date of Birth	Country of Birth

Age	Sex: ☐Male ☐Female	Ethnicity: ☐White ☐African-American ☐Hispanic ☐Asian ☐Native American ☐Other:

Permanent Address: Street

City State Zip County

Current Home Phone ( )	Current Work Phone ( )	Mobile Phone ( )

Personal Email Address	Preferred Method for Contact ☐Home Phone ☐Work Phone ☐Mobile Phone ☐Email

Social Security Number	Marital Status ☐Married ☐Widow/widower ☐Single ☐Divorced ☐Living with Partner

Who referred you to us? (Name)	☐Union ☐Employer ☐CNYCOSH ☐Lawyer ☐Doctor ☐Other:

Name of your Primary Care Physician:	Did your physician refer you here? ☐Yes ☐No

IN CASE OF EMERGENCY NOTIFY: (Name and Phone Number)
DAY

EMPLOYMENT INFORMATION

Are you currently employed? ☐Yes ☐No, if **NO**, are you: ☐Retired? ☐Unemployed? ☐On disability?

What is your occupation: ______________________________

If you are working, has your work status changed because of your illness/injury? ☐No ☐Yes, if **YES**, how?

____

Name and complete address of your **CURRENT OR MOST RECENT** employer:

Name			Phone ( )
Street Address	**City**	**State**	**Zip**

Are you a member of a union? ☐No ☐Yes, if **YES**, what Union and what Local/Chapter#:

____

Name and complete address of **EMPLOYER WHERE ILLNESS OR INJURY OCCURRED** (if different from above):

Name			Phone ( )
Street Address	**City**	**State**	**Zip**

Name and Address of spouse's employer (if covered under his/hers private health insurance plan):

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PATIENT ID #:

MEDICAL INSURANCE

IT IS ESSENTIAL TO INCLUDE ALL INSURANCE INFORMATION PRIOR TO YOUR VISIT.

1. Name and Complete Address of Workers' Compensation Insurance Carrier for Employer Where Illness or Injury Occurred.

Name of Workers' Compensation Insurance Carrier where illness or injury occurred			Phone ( )
Street Address	City	State	Zip
WCB # (if known)	Carrier Case # (if known)	Date of Loss/Injury	

2. Name and Complete Address of Workers' Compensation Insurance Carrier for Your Current Employer. (if different from above):

Name of current Workers' Compensation Insurance Carrier (If different from #1)			Phone ( )
Street Address	City	State	Zip

3. Private Health Insurance – Name and Complete Address of Primary Insurance Carrier

Primary Insurance Carrier Name			Phone ( )
Street Address	City	State	Zip
Name of Person on Insurance Card			Social Security Number
Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent	Policy #:	Group #:	

4. Other Health Insurance – Name and Complete Address of Any Other Insurance Carrier

Other Insurance Carrier Name			Phone ( )
Street Address	City	State	Zip
Name of Person on Insurance Card			Social Security Number
Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent	Policy #:	Group #:	

5. MEDICARE or MEDICAID Subscriber

MEDICARE Subscriber's Name	Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent	
MEDICAID Subscriber's Name	Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent	Medicaid Access #

6. No Insurance – If You Wish to Apply for a Sliding Fee Discount, Please Provide the Following Information.

Total Yearly Household Income	Total Numbers of People in Household

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MEDICAL AND OCCUPATIONAL HISTORY

PATIENT ID #:

List allergies to medicines and other substances and any reactions:

____

____

____

List current medications, vitamins, supplements and over the counter medications dosages, and how often you take them. Use the blank page at the end of this packet if additional space is needed.

____

____

____

PAST MEDICAL HISTORY:

- Anemia ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Blood transfusion ☐ Yes ☐ No
- Chronic bronchitis ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Cataracts ☐ Yes ☐ No
- CHF ☐ Yes ☐ No
- Clotting disorder ☐ Yes ☐ No
- Coronary artery disease ☐ Yes ☐ No
- Diabetes mellitus ☐ Yes ☐ No
- GERD ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Gout ☐ Yes ☐ No
- Heart murmur ☐ Yes ☐ No
- HIV/AIDS ☐ Yes ☐ No
- Hypertension ☐ Yes ☐ No
- Kidney disease ☐ Yes ☐ No
- Low back pain ☐ Yes ☐ No
- Myocardial infarction ☐ Yes ☐ No
- Nerve/muscle disease ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No
- Serious injury ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Substance abuse ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No

Please check box if you have experienced any of the following:

GENERAL

- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Sweating
- ☐ Feeling more tired than usual
- ☐ Fever
- ☐ Unexpected weight change

EYES

- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Light sensitivity
- ☐ Visual disturbance

RESPIRATORY

- ☐ Loud snoring
- ☐ Chest tightness
- ☐ Choking
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Noisy breathing
- ☐ Wheezing

HEART

- ☐ Chest pain
- ☐ Leg swelling
- ☐ Irregular heartbeat

GASTROINTESTINAL

- ☐ Swollen abdomen
- ☐ Stomach pain
- ☐ Bleeding with elimination
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Pain in rectum
- ☐ Vomiting

ENDOCRINE

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urination

HEAD, EARS, NECK, THROAT

- ☐ Face swelling
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Runny nose
- ☐ Post nasal drip
- ☐ Sneezing
- ☐ Sinus pressure
- ☐ Dental problem
- ☐ Drooling
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Voice change

MUSCLE

- ☐ Joint pain
- ☐ Back pain
- ☐ Difficulty standing/walking
- ☐ Joint swelling
- ☐ Muscle pain

URINARY

- ☐ Difficulty urinating
- ☐ Incontinence
- ☐ Pain in lower side/back
- ☐ Urinating more often
- ☐ Sores in penis/vagina
- ☐ Blood in urine
- ☐ Problems with periods
- ☐ Pain in pelvis
- ☐ Sudden urge to urinate
- ☐ Decrease in urination
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal pain

ALLERGY

- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Weak immune system

SKIN

- ☐ Color change
- ☐ Pale skin (more than normal)
- ☐ Skin rash
- ☐ Wound

NEUROLOGICAL

- ☐ Dizziness
- ☐ Face droop
- ☐ Headaches
- ☐ Lightheadedness
- ☐ Seizures
- ☐ Difficulty speaking
- ☐ Fainting
- ☐ Shaking
- ☐ Weakness

BLOOD

- ☐ Swollen lymph nodes
- ☐ Bruise/bleed easily

PSYCHIATRIC

- ☐ Agitation
- ☐ Beahvior problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Depression
- ☐ Hallucinations
- ☐ Hyperactivity
- ☐ Nervousness/anxiety
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas

PAST SURGICAL HISTORY:

Surgery	Yes	No
Appendectomy	☐ Yes	☐ No
Breast Surgery	☐ Yes	☐ No
Breast biopsy	☐ Yes	☐ No
Breast reconstruction	☐ Yes	☐ No
CABG	☐ Yes	☐ No
Cataract removal/IOL implant	☐ Yes	☐ No
Cholecystectomy	☐ Yes	☐ No
Colectomy	☐ Yes	☐ No
Colon Surgery	☐ Yes	☐ No
Colonoscopy	☐ Yes	☐ No
Colostomy	☐ Yes	☐ No
C-Section	☐ Yes	☐ No
Fracture surgery	☐ Yes	☐ No
Gastroplasty	☐ Yes	☐ No
Hernia repair	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No
Joint replacement	☐ Yes	☐ No
Mastectomy	☐ Yes	☐ No
Ovary removal	☐ Yes	☐ No
Prostate surgery	☐ Yes	☐ No
Small intestine surgery	☐ Yes	☐ No
Spine surgery	☐ Yes	☐ No
Tonsillectomy	☐ Yes	☐ No
Tubal ligation	☐ Yes	☐ No
Valve replacement	☐ Yes	☐ No
Vasectomy	☐ Yes	☐ No

PATIENT ID #:

1. **List any other medical diagnoses/surgical procedures for which you have received treatment or for which you have been hospitalized; now or in the past.**

____

____

____

FAMILY HISTORY (Please list major illnesses of family members):

	Living	Major Illnesses (such as alcohol abuse, heart disease, cancer, diabetes, stroke)
Mother	☐Yes ☐No	
Father	☐Yes ☐No	
Siblings – List your Brothers and Sisters with ages and illness		
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	
Children – List your Sons and Daughters with ages and illness		
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	

☐Adopted ☐Family history unknown

SOCIAL HISTORY:

Alcohol Use . . . .☐ Yes ☐ No

Drinks per week: ____________ **Glasses of wine**

____________ **Cans of beer**

____________ **Shots of liquor**

____________ **Drinks containing 0.5oz. of alcohol**

Comment: ______________________________

Tobacco Use. . . . .☐ Yes ☐ No

Years: ____________

Packs per day: ____________

Smokeless tobacco: ☐ **Yes** ☐ **No**

Quit date: ____________

Ready to quit: ☐ **Yes** ☐ **No**

PLEASE LIST YOUR CURRENT PHARMACY INFORMATION TO HELP EXPEDITE YOUR VISIT:

Pharmacy Name: ______________________________

Phone Number: ______________________________

Address: ______________________________

STREET CITY ZIP CODE

Pharmacy Name: ______________________________

Phone Number: ______________________________

Address: ______________________________

STREET CITY ZIP CODE

List your environmental exposures:

A. How long have you been living at your current residence: . . . ______

B. Age of house:. . . . . . ______

C. Type of home heating system: . . . . . . ______

D. Water source: . . . . . . ______

E. Pets:. . . . . . ______

F. Recent/current residential remodeling, if yes, when: . . . . ______

G. Do you live close to farms, factories, highways, dump sites, other . . . . . . ☐ Yes ☐ No

If YES to Question G, Please give Details, if necessary: ______

______

______

How Many Persons Are Currently Living In Your Household . . . . ______

How Much Schooling Did You Complete? (last level completed 1-17+ years) . . . . . ______

Should the New York State Department of Health wish to conduct future studies, would you be willing to be contacted for possible participation? . . . . . . ☐ Yes ☐ No

Has your illness/injury affected your ability to perform the following:

Tasks around the house . . . . . . ☐ Yes ☐ No

Care for family/children. . . . . . . ☐ Yes ☐ No

Recreation . . . . . . ☐ Yes ☐ No

No affect . . . . . . ☐ Yes ☐ No

In your own words, why are you coming to the Occupational Health Clinical Center?

______

______

______

______

______

______

What are your hobbies, interests and recreational activities:

______

______

______

______

______

______

OCCUPATIONAL HISTORY: List the jobs you've had since you first started working. Also include the years worked at each job. Include any military service. Use the blank page at the end of this packet if additional space is needed.

DATE	EMPLOYER NAME, PRODUCT OR SERVICE PROVIDED	JOB TITLE/ DUTIES	MAJOR EXPOSURES (for example: dusts, chemicals, noise, repetitive motion, stress)	CO-WORKERS WITH SYMPTOMS? ATTEMPTS TO FIX PROBLEM?	PROTECTIVE EQUIPMENT (for example: respirator, hearing protection, gloves)
EXAMPLE: 1987-1989	EXAMPLE: ACME INDUSTRIES SHOE POLISH MANUFACTURER	EXAMPLE: INSPECTOR	EXAMPLE: SHOE POLISH, SOLVENTS, TRICHLOROETHYLENE	EXAMPLE: CO-WORKERS W/HEADACHES FANS PUT NEAR MACHINES	EXAMPLE: RESPIRATOR, EAR PLUGS

PATIENT ID #:

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PATIENT COPY OF OHCC BILLING POLICY
PLEASE KEEP

The Occupational Health Clinical Center (OHCC) is committed to accessible services for all patients regardless of income or health insurance status. OHCC does bill for services and we depend on revenues from patient care so we can continue to care for and expand our services for patients.

Most charges for medical services provided at the OHCC will be most likely be covered through either your private health insurance or Workers' Compensation. You will be billed for the remaining balance in your account for any services not covered by Workers' Compensation or your private insurance. You will need to pay any co-payment or unmet deductible that your insurance company requires. We have a sliding fee scale to make our services as affordable as possible.. If paying the remaining balance would cause a hardship for you and your family or if you do not have insurance coverage, we will be happy to work out a plan to spread payments out over a reasonable amount of time, and/or adjust your bill according to the sliding fee scale rate. Every effort will be made to ensure that you are able to get appropriate care without economic hardship.

To determine your bill at our sliding fee scale rate, we will need to know your household gross (before taxes) annual income and the number of members in your household. Please call or write us with this information and we will make the adjustment to your account balance appropriately.

If you have any questions or concerns about this policy, please call or write our Billing Clerk.

UPSTATE MEDICAL UNIVERSITY

PATIENT BILL OF RIGHTS

The Occupational Health Clinical Center (OHCC) is a member of the Association of Occupational and Environmental Clinics (AOEC). As an AOEC member, we are committed to provide you quality health care, and to help you understand the nature of your illness and any risks to your health. Our primary obligation is to you, our patient. We assure you that your medical care will be handled with compassion, and strict confidence.

As a patient of our clinic, you have a right to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the OHCC will provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, age, or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care or if appropriate, arrangements will be made for transfer to an emergency facility.
5. Be informed of the name and position of the clinician who will be in charge of your care.
6. Know the names, positions, and functions of any OHCC staff involved in your care. You have a right to refuse their treatment, examination or observation.
7. A smoke-free environment.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Refuse treatment and be told what effect this may have on your health.
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Participate in all decisions about your treatment.
13. Review your medical record without a charge and obtain a copy of your medical record for which the OHCC can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
14. Receive an itemized bill and explanation of all charges.
15. Complain without fear of reprisals about the care and services you are receiving, to have the OHCC respond to you, and if you request it, a written response. If you are not satisfied with the OHCC's response, you can complain to the New York State Department of Health. The OHCC will provide you with the Health Department telephone number.
16. Obtain a list of contracts and grants that this clinic has with any organizations, such as government agencies, industries and companies, labor unions, or community groups.

As an AOEC clinic, we promise to:

1. Maintain your records in strict confidence and not release them to anyone outside this clinic without your express written permission. (Your filing of workers' compensation, health insurance, or legal claims may require you to release your records).

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2. Help you obtain information about workers' compensation, social security, disability, and other health and welfare benefits if you request such information.
3. Provide information on your OSHA rights, assist you in getting a workplace inspection, and help you improve health and safety at your worksite.
4. Provide legal testimony of our findings, if necessary.
5. Declare any possible conflict of interest by providing you with a list of our grants and contracts, if requested.
6. Explain the results of all medical tests and procedures performed under our direction.
7. Help you understand the causes of your illness and risks to your health.
8. Work with you to prevent future health problems.

Date: ____________________

To update our records and ensure the timely mailing of reports to your attorney, please supply us with the following information:

Patient Name (please print): _____________________________________

Date of Birth: _____________________________

Attorney Name:____

Address: ____

Phone Number: ___________________________

Fax Number: ___________________________

Attorney Email address: ____

I authorize the release of copies of the C4, office notes and diagnostics to be mailed directly to my attorney. I will notify the Occupational Health Clinical Center of any changes.

Signature: ____

Thank you

UPSTATE
UNIVERSITY HOSPITAL

PERMISSION TO DISCUSS CONFIDENTIAL HEALTH INFORMATION

Patient Name: ______________________ MR#: ______________

Account #: ______________ DOB: __________ Date: __________

This form must be completed if you wish to grant University Hospital permission to discuss confidential health information about your care with family members, friends, and others involved in your care who may inquire. As explained in our 'Notice of Privacy Practices', we must provide you with the opportunity to agree or object before we can discuss some of your confidential health information with family and friends who are not making healthcare decisions on your behalf. If you wish to designate one or two individuals with whom we can discuss your confidential health information, please use the space below to indicate their name(s). It is important that you be made aware of the following before granting such permission:

- The information we are permitted to discuss with the individuals you name is limited to general care and treatment information and will not include information that is given greater protection under law such as HIV-related information, mental health information, substance abuse treatment information, genetic information, or any other information that your healthcare provider determines, in the exercise of professional judgment, could be of a sensitive nature.
- The individuals you name below must give us their name, and may be asked to give us your date of birth, when they inquire before we can discuss any information with them. If the inquiry is made in person, we may ask the individual for photo identification.
- If you are receiving outpatient services you will be asked to review and renew this permission yearly.
- If you are the personal representative giving permission on behalf of the patient, this form will expire if the patient becomes capable of making their own healthcare decisions.

This permission can be revoked at any time by sending a letter to the Institutional Privacy Administrator at 750 East Adams St., Syracuse, New York 13210.

I give my permission to University Hospital* to discuss my confidential health information with the following individuals (PLEASE PRINT):

1. Name: ______________ Telephone #: ______________ Relationship: ______________

2. Name: ______________ Telephone #: ______________ Relationship: ______________

Patient Signature: ______________ Date: ______________

Personal Representative's Name ______________ Signature: ______________

Staff Witness: ______________ Date: ______________

*Specify Outpatient Service: ______________