



Dear Client:

Your appointment has been scheduled at the Central New York Occupational Health Clinical Center as noted above on the pink appointment card. **Prior to your appointment, please fill out and return to us the enclosed forms which are listed below.** Please mail them to: 6712 Brooklawn Parkway, Suite 204, Syracuse, NY 13211-2195 **ONLY** if they will arrive here prior to your appointment. If not, please bring them with you on the day of your appointment.

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 our Syracuse office at (315) 432-8899.

Thank you for your cooperation.



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FOR OFFICE USE ONLY

CENTRAL NEW YORK OCCUPATIONAL HEALTH CLINICAL CENTER
6712 BROOKLAWN PARKWAY, SUITE 204
SYRACUSE, NY 13211-2195
(315) 432-8899

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
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Age	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other:
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Permanent Address:	Street
City	State Zip County

Current Home Phone ()	Current Work Phone ()
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Social Security Number	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widow/widower <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Living with Partner
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Who referred you to us? (Name)	<input type="checkbox"/> Union <input type="checkbox"/> Employer <input type="checkbox"/> CNYCOSH <input type="checkbox"/> Lawyer <input type="checkbox"/> Doctor <input type="checkbox"/> Other:
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Name of your Primary Care Physician:	Did your physician refer you here? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IN CASE OF EMERGENCY NOTIFY: (Name and Phone Number)

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):



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)	

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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Policy #:	Group #:	

5. MEDICARE or MEDICAID Subscriber

MEDICARE Subscriber's Name	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
MEDICAID Subscriber's Name	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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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PAST MEDICAL HISTORY:

1. List major health problems/diseases for which you have received treatment or for which you have been hospitalized; now or in the past.

2. List all surgeries either as an in-patient or out-patient.

3. List current medications and dosages.

List vitamins and over the counter medications:

List supplements:

4. List allergies to medicines and any reactions.

5. List allergies to other substances and any reactions.

6. Any previous history of childhood allergies or asthma Yes No

7. List serious injuries from accidents (broken bones, head injuries, etc.).

8. Immunizations: Did you receive childhood immunizations? Yes No; Pneumovax? Yes No

Date of your last tetanus shot? _____ Date of last flu shot? _____

SOCIAL HISTORY:

Tobacco Use

1. Have you ever smoked cigarettes? Yes No
(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.)

If YES to Question #1

A. Do you now smoke cigarettes (as of one month ago)? Yes No

B. How old were you when you first started regular cigarette smoking? (Age in years) _____

C. If you have stopped smoking cigarettes completely, how old were you when you stopped?
..... (Age in years) _____

D. How many cigarettes do you smoke per day now? _____

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

F. Do you or did you inhale the cigarette smoke? Not at all Slightly Moderately Deeply



PATIENT ID #:

2. Have you ever smoked a pipe regularly? Yes No
(Yes means more than 12 oz. of tobacco in a lifetime)

If YES to Question #2

A. 1. How old were you when you started to smoke a pipe regularly? . . (Age in years) _____

2. If you have stopped smoking a pipe completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still smoking a pipe? Yes No

B. 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.)

C. How much pipe tobacco are you smoking now? _____ oz. per week.

D. Do you or did you inhale the pipe smoke? Not at all Slightly Moderately Deeply

3. Have you ever smoked cigars regularly? Yes No
(Yes means more than 1 cigar a week for a year).

If YES to Question #3

A. 1. How old were you when you started smoking cigars regularly? . . (Age in years) _____

2. If you stopped smoking cigars completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still smoking cigars? Yes No

B. On the average over the entire time you smoked cigars, how many cigars did you
smoke per week? _____

C. How many cigars are you smoking now? _____ per week.

D. Do you or did you inhale the cigar smoke? Not at all Slightly Moderately Deeply

4. Have you ever used smokeless tobacco regularly? Yes No

If YES to Question #4

A. 1. How old were you when you started using smokeless tobacco regularly? (Age in years) _____

2. If you stopped using smokeless tobacco completely, how old were you when you stopped?
..... (Age in years) _____

3. Are you still using smokeless tobacco? Yes No

B. On the average over the entire time you used smokeless tobacco, how much did you
use per week? _____

C. How much are you using per week now? _____ per week.

Alcohol Use (list amount of alcoholic beverages consumed each day/week/month)

A. Do you drink alcohol? Yes No

B. What type of alcoholic beverages do you drink? _____

C. How many per day? _____

List your hobbies/recreational activities:



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

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

	Living	Age if Living or Age at Death	Major Illnesses
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Siblings – List your Brothers and Sisters with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Children – List your Sons and Daughters with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Relatives – with ages and illness			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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 next page if additional space is needed.

DATE	EMPLOYER NAME, PRODUCT OR SERVICE PROVIDED	JOB TITLE/DUTIES	MAJOR EXPOSURES <small>(for example: dusts, chemicals, noise, repetitive motion, stress)</small>	CO-WORKERS WITH SYMPTOMS? ATTEMPTS TO FIX PROBLEM?	PROTECTIVE EQUIPMENT <small>(for example: respirator, hearing protection, gloves)</small>
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 #:

REVIEW OF SYSTEMS

Please check ANY symptoms which you have experienced in the past three (3) months.

- General:** weight change weakness
 heat intolerance night sweats
 chills excessive thirst
 fever cold intolerance
-

- Skin:** persistent rash persistent itching
-

- Head, Ears, Eyes,** dizziness jaw pain (TMJ)
Nose, Throat: fainting spells dental problems
 frequent headaches dentures
 severe headaches difficulty chewing
 sinus trouble difficulty swallowing
 sinus congestion hoarseness
 nasal congestion frequent colds
 runny nose neck swelling
 sneezing poor eyesight
 post nasal drip double vision
 loss of smell watery, itchy eyes
 change in smell hearing trouble
 loss of taste ringing in ears
 bad taste in mouth hearing aid
 sores in mouth ear ache
 bleeding gums ear discharge
-

- Lungs:** cough phlegm
 wheezing chest pain with deep breathing
 shortness of breath coughing blood
-

- Heart:** chest discomfort or pain irregular heartbeat
 swollen ankles leg or calf pain when walking
 shortness of breath laying down flat wake up gasping for breath
-

- Gastrointestinal:** change in appetite change in bowel habits
 frequent or severe heartburn constipation
 frequent or severe nausea prolonged or frequent diarrhea
 frequent or severe vomiting blood in bowel movements
 vomiting blood black bowel movements
 frequent or severe abdominal pain hemorrhoids
 frequent bloating yellow jaundice
-

- Urinary:** frequent urination painful urination
 bloody urine difficulty urinating
 urinating more than 2 times per night
-

Bones, Joints, Muscles: joint pain
 muscle aches or cramps/tightness

joint swelling
 varicose veins

Nervous System: tingling (pins & needles)
 difficulty with balance
 tremor (shaking, trembling)
 convulsions (seizures, fits, epilepsy)
 fainting spells or blackouts
 lack of energy
 trouble sleeping
 nervousness
 trouble concentrating

memory troubles
 confusion
 depression
 crying spells
 mood swings
 trouble getting along with people



PATIENT ID #:

REVIEW OF SYSTEMS: *continued*

Please check ANY symptoms which you have experienced in the past three (3) months.

- Men:** discharge from penis lump or pain in testicle
 loss of sex drive sexual trouble
-

- Woman:** breast lump or discharge discharge from vagina
 unusual bleeding from vagina loss of sex drive
 sexual trouble
-

- Both:** Difficulty (you or partner) in becoming pregnant.

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

- tasks around the house
- care for family/children
- recreation
- no affect



PATIENT COPY OF CNYOHCC BILLING POLICY PLEASE KEEP

The Central New York Occupational Health Clinical Center (CNYOHCC) is committed to making our services accessible to all patients regardless of income or health insurance status. CNYOHCC is, however, depending on revenues from patient care to allow us to continue our work and hopefully expand the services we are able to offer. Consequently, we bill for the medical services we provide.

Chances are that a significant portion of your bill for medical services provided here at the CNYOHCC will 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 are, however, responsible for any co-payment or unmet deductible that your insurance company requires. To make sure our services remain accessible, we have developed a sliding fee scale. 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 obtain 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 appropriate adjustment to your account balance appropriately.

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



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PATIENT BILL OF RIGHTS



The Central New York Occupational Health Clinical Center (CNYOHCC) 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 CNYOHCC 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 CNYOHCC 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 CNYOHCC 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 CNYOHCC respond to you, and if you request it, a written response. If you are not satisfied with the CNYOHCC's response, you can complain to the New York State Department of Health. The CNYOHCC 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).



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.