Oregon
OCCUPATIONAL MEDICINE
Service, Gratitude, & Integrity

Clackamas Clinic
9290 SE Sunnybrook Blvd Ste 220, Clackamas, OR 97015
F:503-343-8545 - Monday-Friday 8am-5pm

Hillsboro Clinic
1200 NE 48th Ave, Suite 1000, Hillsboro, OR 97124
F:503-596-2182 - Monday-Friday 7am-6pm

Tualatin Clinic
19365 SW 65th Ave, Suite 100, Tualatin, OR 97062
F:503-563-5392 - Monday-Friday 8am-5pm

Patient Registration/Information

Name:	**Date of Birth:**
Phone Number:	**Address:**
Sex Assigned At Birth: **Current Gender Identity:**	**City/State/Zip:**
Email Address:	❑ ***I would like email reminders for future appointments***
Company Name: **Company Address:**	**Company Contact:** **Phone Number:**

Injury Care: ☐ First Report of Injury ☐ Report of Aggravation ☐ Changing of Attending Physician ☐ Emergency/Urgent Care Follow Up	**Post-Accident Services:** ☐ Need Post Accident BAT/Drug Screen ☐ Breath Alcohol Test Already Done at ER ☐ Saliva Alcohol Test Already Done at ER ☐ Drug Screen Already Done At ER

Date and Time injury occurred:

Describe what your injury is and how your injury occurred in detail (PLEASE BE SPECIFIC):

Interpreter Services:
☐ I do need a Medical Interpreter for the _____ language.
☐ I do not need an Medical Interpreter for my appointment

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Consent for Injury Care
Release of Information & Financial Policy Agreement

Employee Name: _____

DOB: _____

Employer: _____

Consent for Treatment & Release of Information

I consent to and authorize the examining Medical Provider (MD, DO, NP, PA, PT), and any associates to conduct physical exams and perform such tests and treatment as the examining physician deems necessary or appropriate. I also authorize personnel of the clinic to provide routine services requested by the Provider. The Provider will inform me as to the nature of any procedures, the alternatives to treatment and the risks that are involved. I will be given an opportunity to ask questions and have my questions answered. I understand that this consent to treatment is effective for the duration of my treatment for this injury unless revoked in writing by me.

I authorize OOM to disclose information regarding this injury to my employer and insurance carrier for the duration of my treatment as allowed by law, unless this release is revoked in writing by me. I hereby release the clinic employees and contractors from any liability from such disclosure.

Financial Policy & Patient Participation Agreement

We are committed to providing you with the best possible care. In order to achieve this goal we need your active participation in your care and understanding of our policies.

Worker's Compensation Fees and Process: Our fees are in accordance with Oregon's maximum allowable fee schedule. We will follow all applicable Oregon Administrative Rules* in accordance with these claims (OAR 436-009-000x). This includes submitting appropriate documents, billing and corresponding with the Worker's Compensation carrier (for your employer at the time of the injury/ illness). Similarly, you must submit the appropriate worker related forms and respond to requests for additional information from the insurer. Failure to do so could result in claim denial by the insurer. We request your social security number as it is used to identify your claim. Without this number your claim may be denied by the carrier.

Claim Acceptance or Denial: Oregon Law* allows the insurer sixty days to accept or deny your claim. In the event that your claim is denied, you have sixty days to appeal the decision (OAR 436-060-0140). If you do not to appeal or your appeal is not accepted, a final denial will be issued by the insurer. Once a final denial is issued, **you** are responsible for the charges incurred for the services we have provided. It is expected that you will pay the balance of your account in full within 90 days.

Personal Health Insurance: We do not bill Personal Health Insurance for any services we provide (effective 3/1/19). Your personal health insurance is a contract between you, your employer and the insurance company; we are not a party to that contract. You may choose to seek reimbursement from your personal health insurance for charges you pay to us. Our billing specialists can provide you with a superbill which includes the necessary information and insurance codes for you to submit to your insurer. We do not work with your personal health insurance directly. If you choose to seek reimbursement from them, the process is fully your responsibility.

Information Regarding Your Participation in Your Care: Healing requires a partnership between you and us. It is expected that you are an active participant in your care. If you do not show up for or cancel your scheduled appointments, we are obligated to inform your employer and your Worker's Compensation insurer. Repeated no shows or canceled appointments may negatively affect the status and compensability of your claim. After two missed appointments we may discontinue care of your injury.

I understand that in the event of a denial by the worker compensation carrier, after the appeal process is exhausted, I am personally responsible for the charges incurred. I understand that delinquent accounts may be assigned to a collection service and I will be charged for expenses, including any reasonable attorney fees. I understand in the event of a returned (NSF) check there will be a $30 minimum charge and payment will be required in the form of a credit card, cashier check or money order.

I have been given the opportunity to read the above Oregon Occupational Medicine policies and I agree to the terms above.

Patient Signature _____ Date _____

OOM Employee _____ Date _____

*Oregon Administrative Rules: http://tinyurl.com/y3nqkgbu (https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=75)

Optional: Release of Information

☐ I authorize the staff of OOM to leave a message or send texts to this phone number: _____
or email me at the following address:

☐ I authorize the staff of OOM to disclose information regarding my care (including appointment dates, times or medical information) to:

☐ Spouse (name): _____ ☐ Other (name/relationship): _____

This release is for the duration of my care for this injury or until I revoke this release in writing.

Patient Signature _____ Date _____

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WC Initial Patient Medical History

Name:_____

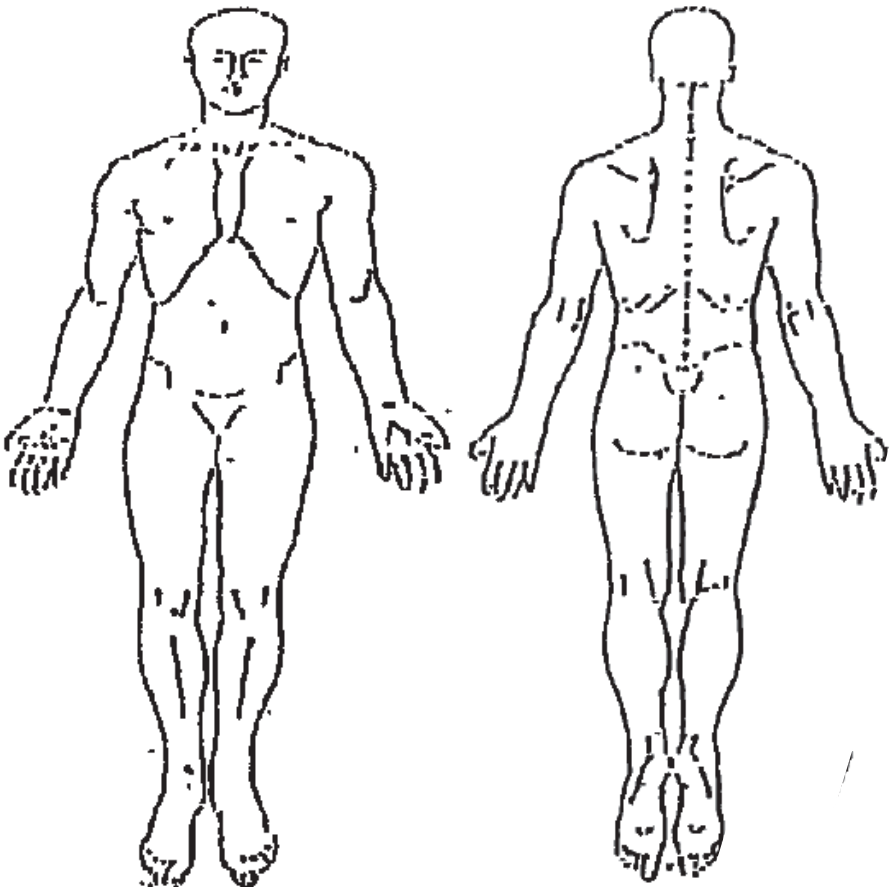
DOB:_____ **Today's Date:**_____

I. CURRENT MEDICAL INFORMATION

1. Do you currently have pain as a result of the injury/illness you are here for? ☐ **Yes** ☐ **No (skip to #2)**

If yes, please mark the areas where you currently have pain using the sensations/symbols below:

Aching	**Numbness**	**Pins and Needles**	**Burning**	**Stabbing**
▲▲▲	= = =	●●●	X X X	/ / /



Pain Scale

0	Pain Free
1	Very Mild Annoyance Mild aches, no medication needed
2	Minor Annoyance Dull aches, no medication needed
3	Annoying enough to be a distraction Non-prescription medication needed
4	Can be ignored if you are really involved, but still distracting, often talked about. Non-prescription medication removes pain for 3-4 hours
5	Can't be ignored for more than 30 minutes High doses of non-prescription medications may help minimally
6	Can't be ignored for any amount of time, you can still go to work and participate in social activities. Non-prescription medications only mildly effective in large doses
7	Makes it difficult to concentrate, disrupts or interferes with sleep. You can function only with effort. Non-prescription medication not effective at all
8	Physical activity severely limited. You can read and converse with effort
9	Nonfunctional for all practical purposes. Cannot concentrate, physical activity halted. Panic depression and related emotional and social issues set in notwithstanding treatment.
10	Totally nonfunctional. Unable to speak. Crying out or moaning uncontrollably.

2. Do you take any medications (prescription, non prescription) supplements or vitamins? **Yes**, please list: **No**

3. Are you allergic to any medicine, food, clothing, bee stings or other substances? ☐ **Yes**, please list: ☐ **No**

4. When was your last tetanus shot? _____ What is your weight? _____ Height? _____

II. PAST MEDICAL HISTORY (***please list pertinent information from the last five years***)

1. Have you had any surgeries? ☐ Yes ☐ No
   Please list:
2. Have you had any injuries? ☐ Yes ☐ No
   Please list:
3. Please list any present or past illnesses (include approximate year/date):

III. WORK HISTORY

1. How long have you worked at your current job?_____
2. Have you had any recent changes in duties/responsibilities? ☐ Yes ☐ No
   Please list: _____
3. What kind of exposures do you have?
4. Current Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-employed ☐ Unemployed

IV. SOCIAL HISTORY

1. Do you smoke? ☐ Yes ☐ No How many packs per day?_____
2. Do you drink alcohol? ☐ Yes ☐ No How much? _____
3. Do you drink caffeinated beverages? ☐ Yes ☐ No How many per day? _____
4. Do you use recreational drugs? ☐ Yes ☐ No Please list: _____
5. Do you have any children? ☐ Yes ☐ No Ages: _____
6. What are your hobbies? _____
7. Do You: Live Alone? ☐ Yes ☐ No Have stairs? ☐ Yes ☐ No Have help at home? ☐ Yes ☐ No

V. FAMILY HISTORY

1. Do you or your immediate family members have:

Cancer	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Other Diseases	☐ Yes	☐ No			
If yes, please list:					

VI. REVIEW OF SYMPTOMS

1. Do you currently experience:

Night Sweats	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Rashes	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
Numbness	☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No
Blood in Stool	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No
Muscle Pain	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Irregular Heart Rate	☐ Yes	☐ No	Stomach Pain	☐ Yes	☐ No
Fever then Chills	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Excessive Hunger	☐ Yes	☐ No

Physician Comments/Notes: