Patricia H. Janki, M.D., P.A.
Occupational Medicine and On-Site Services

Date: _____/_____/_______

PATIENT INFORMATION:

First Name: ____________________ Last Name: ____________________ MI: _______

Address: ____

City: ____________________ State: ____________________ Zip: ______________

SSN#: __________________ Date of Birth: _____/_____/_____ DL#: ______________

Telephone Numbers:

Home: (____) _____-________ Work: (____) _____-________

Cell: (____) _____-________ Alt: (____) _____-________

Email: ________________________________

Emergency contact: ___________________________ Tel: (_____) _____-__________

Employer: ____

Employment Status: □ Full-time □ Part-time □ Student □ Retired □ Un-employed

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □Native American □Asian □White □African American □Unknown □Refuse to Report □Other:___________

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Refuse to Report □ Unknown

Language: □ English □ Spanish □ Other:_________

Consent for Testing

I authorize Dr. Janki and/or staff to perform the audiogram test ordered by my employer. I am giving permission to Dr. Janki and her associates to release the results/medical records pertaining to the audiogram test ordered by my employer.

Print Name: ________________________

Signature: ________________________

HEALTH AND HISTORY

Modified 7/24/2009

What is your current occupation?

Illness / Injuries: Please check if you have ever had or if present

Illness / Injury	*Yes*	*No*	*Illness / Injury*	*Yes*	*No*	*If Yes, explain:*
High Blood Pressure			STD's			
Diabetes			Yellow Jaundice			
Fainting Spells			Hepatitis			
Peptic Ulcers / Bleeding			Kidney Stones			
Heart Attack / Murmurs			Lung Problems			
Chest Pain / tightness			Stomach Problems			
Shortness of breath			Thyroid Problems			
Stroke			Childhood Disease			
Cancer			Asthma			
Anemia			Back/Joint/Ligament			
Skin Allergy / Reaction			Broken bones			
Gallstones			Any Disability			
Depression / Anxiety			Loss of fingers/limb			

List all the current "medications"?

ALLERGIES TO DRUGS:

Personal Habits / Risk Factors

Habit / Risk Factors	*Yes*	*No*	
Do you have any Pets?			What type:
Do you have any hobbies?			What type:
Is your job a risk to your Health?			Explain:
Are you married?			Status:
Are you and your partner monogamous (no other sex partners)?			
Recent Travel?			To Where:
Are you concerned about your health?			Explain:
Do you exercise?			What type:

Immunizations:	**Date:**		**Date:**
TB/PPD Skin Test		Hepatitis A	
Influenza/Flu Shot		Hepatitis B Series	
Pneumococcal/Pneumonia Shot		Tetnus	

FEMALES ONLY:

Are you Pregnant? yes no	How many children have you delivered?
Date of last Menstrual Period:	Is your cycle regular? yes no

The above information is true and accurate to the best of my knowledge.

Patient Signature, or guardian if patient is a minor: ______________________ Date:__/__/__

Patricia H. Janki. M.D., P.A. **Treatment Authorization Form**

Modified 5/2/2007

Patient Name ______________________________ Date ________________

Consent for Treatment: I authorize Dr. Janki and associates, to perform the necessary drug test, physical examination, and/or to render the necessary medical treatment. This includes, but is not limited to, medical examination, diagnosis, ex-rays, medical procedure(s), and diagnostic laboratory test to be performed by the designated clinic staff.

Only if work related: I voluntarily give consent to Dr. Janki's clinic to obtain any specimen of my urine, blood, saliva, hair and/or breath for the purpose of screening for the presence of drugs and/or alcohol, if necessary. **I further give consent to release my records to my employer or potential employer if applicable. I understand that I will only be treated for the designated injury as by my employer.**

Release of Medical Records: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referring physician, and/or specialty provider, if any, who referred me here

Insurance Authorization/Financial Agreement: I request that payment of authorized benefits be made to Dr. Janki on my behalf, for any services provided to me. I authorize any holder of medical and other information about myself to be release to, but not limited to: Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, utilization review organization or any other governmental or private payer responsible for paying such benefits and any information needed to determine these benefits or benefits for related services. I give authorization to release my information to my employer, prospective employer and workers' compensation carrier when applicable. I agree to pay for all charges not covered by a third party payer. I understand that it is my responsibility to pay all deductibles, co-pays, and charges for medical services rendered that are not covered by my insurance. It is my responsibility to verify my insurance ineligibility and should my account be referred for collection, then the undersigned shall pay the necessary collection expenses or attorney fees.

Confidentiality: It is Dr. Janki's clinic policy to protect all medical records against loss, theft, tampering, destruction and access by unauthorized persons per HIPPA guidelines. I understand and give Dr. Janki permission for my medical records to be periodically reviewed by appropriate utilization committee, quality assurance personnel, TWCC, Workers Compensation Carriers, third party payers, employers and national accreditation or certification committees.

Medication refills will be provided only when considered appropriate by Dr. Janki.

- A patient must be evaluated before receiving a prescription.
- We require a 48hour notification for a refill request.
- Please call before you run out of medication to request a refill.
- **If a narcotic, muscle relaxant, tranquilizer, is lost, it will not be replaced or refilled.**
- If you feel that your medication is not helping your condition, please call the office and notify the nurse or Dr. Janki. Do not take it upon yourself to increase your dosage.

I authorize a copy of this authorization to be used in place of the original.

I ______________________________, have fully read and/or was explained to me with ample time the above
(Print Patient Name)

contents and policies. I fully understand and accept its contents in its entirety.

Patient Signature: ______________________________ Date ____/____/____

If patient < 18 years old, biological parent or legal guardian must sign below:

I authorize Dr. Janki & associates to evaluate and treat my child.

Signature: ______________________ Print ____________________ Date ____/____/____