

Appointment Checklist (please bring the following to your appointment):

1. Completed patient information forms (included in this packet)
2. Insurance Card(s)
3. Driver's License or valid photo ID
4. Claim Information (if auto or worker's compensation injury)
5. Copay/Deductible Payment
6. Primary Care Referral (if applicable)
7. Any applicable imaging studies done in the past year (includes X-rays, MRI's, CT scans, and EMG's)

Patient Guidelines:

Thank you for choosing us as your healthcare provider. It is our mission to provide you with an exceptional patient experience and return you to your activities as quickly and safely as possible. Please help us in our mission to provide high quality, integrated care by adhering to the following policies while in our facility:

1. **Check-in** – Check in at the front desk prior to each appointment. Your copay will be collected prior to your appointment and will make a copy of your insurance card.
2. **Check-out** – All patients must check out after each appointment regardless of if a follow-up appointment is necessary.
3. **Copays** – Your copay is due at the time of your appointment. If you do not have your copay, your appointment will be rescheduled. If your insurance changes during the course of your treatment let us know right away so you do not get billed for any unpaid balances.
4. **Referrals** – If your insurance requires a referral, it is your responsibility to bring it with you. You will be responsible for payment of your office visit if you do not have it.
5. **Appointment Times** – If you are 10-15 minutes late for your appointment time, you may be asked to reschedule your appointment. If you know in advance you will be running late, please call and let us know. Being early is helpful, but it does not mean you will be taken back early.
6. **Monitor Children** – If you do bring children to your appointment, we ask that you supervise them and do not leave them alone in the waiting room.
7. **Cell Phones** – Refrain from using your cell phone during your appointment when you are with physician, clinician or other member of our staff.
8. **Form Fee** – There is a \$15 fee for all disability or FMLA forms that need to be completed by a doctor. Allow 5-7 business days for your form to be completed. You will be contacted when they are ready.



Coordinated Health
Care on Call
Physical Evaluation Report Form

Name: _____ Date: _____

Employer: _____ Job Title: _____

The individual is:

Medically cleared to perform the job as described by the job description provided by the employer for the purpose of this physical.

Medically cleared without job description.

Based on the tests administered and the medical examination performed under the protocol established by the employer, this employee has no apparent communicable disease(s) that would interfere with the performance of their duties.

Medically cleared with the following restrictions or modifications:

NOT medically qualified to perform the job as described by the job description provided by the employer for the purpose of this physical.

Medical hold pending further medical data requested below:

1. _____
2. _____
3. _____

The patient has been informed of the medical results of this physical and recommendations.

Employee's Signature: _____

Examiner's Signature: _____

Examiner's Name: _____



Coordinated Health
Care on Call

Name: _____ DOB: _____

Family Doctor: _____ Specialists: _____

Type of work applying for: _____

Brief description of Job Duties: _____

History:

1. Have you ever had any serious illness or injury resulting in more than 2 weeks of disability? YES NO

If YES, explain: _____

2. Have you ever been hospitalized? YES NO

If YES, explain: _____

3. Have you ever had surgery? YES NO

If YES, explain: _____

4. Have you ever been advised to have surgery that was not done? YES NO

If YES, explain: _____

5. Please list your current medical conditions: _____

6. Please list all of your medications and dosages: _____

7. Please list any ALLERGIES you may have: _____

Family History:

Diabetes Mellitus High Blood Pressure Mental Illness Alcoholism

Cancer Heart Disease Tuberculosis or Lung Disease Other _____



Social History:

1. Have you ever smoked tobacco? YES NO
If YES, how much? _____ for how many years? _____ quit date: _____
2. Have you ever used alcohol? YES NO
If YES, how much? _____
3. Have you ever used drugs? YES NO
If YES, drugs used: _____

Immunizations and Infectious Diseases:

1. Have you had your childhood immunizations and other infectious disease vaccinations?
 MMR DTP Polio HIB Hepatitis B, date: _____
 Tetanus, date: _____ Typhoid, date: _____ Varicella, date: _____
2. Have you ever experienced a reaction to previous immunizations? YES NO
If YES, explain: _____
3. Have you ever had a positive TB test or positive chest x-ray for TB? YES NO
4. Have you ever been exposed to anyone with active TB? YES NO
5. Have you ever received treatment for active TB? YES NO
6. Have you traveled outside the US within the past year? YES NO

Work History:

1. Have you ever been refused employment for a health reason? YES NO
If YES, explain: _____
2. Have you ever been restricted from work for a health reason? YES NO
If YES, explain: _____
3. Have you ever been forced to leave employment for a health reason? YES NO
If YES, explain: _____
4. Have you ever been refused or discharged from the military for a health reason?
 YES NO If YES, explain: _____



Coordinated Health
Care on Call

Work History Continued:

5. Have you ever been refused life insurance? YES NO

If YES, explain: _____

6. Have you ever worked with or have been exposed to the following? YES NO

asbestos coal dust chemicals cotton dust radiation lead

loud noise skin irritants heavy lifting heavy metals nuclear materials

7. Have you ever worked in a job that requires repetitive motions? YES NO

If YES, overhead work bending twisting grasping gripping

8. Have you ever worked in a job that requires the use of respirator equipment?

YES NO

I, the undersigned, do hereby certify that the answers to the above questions are true to the best of my knowledge and understand that any falsification, misrepresentation or omission concerning permission for the results of my medical use, abuse and or treatment and or mental health diagnosis and or treatments that I have completed, to be transmitted to the designated corporate physician and to relevant personnel.

Signature: _____

Printed name: _____

Date: _____



Coordinated Health

REVIEW OF SYSTEMS

Patient Name _____

Today's Date _____

Please answer the following questions to the best of your ability.

IN THE PAST 6 MONTHS:

	HAVE YOU HAD?	ARE YOU BEING TREATED BY A DR. FOR?
General:		
1. Any recent unexplained changes in weight?	___ NO ___ YES	___ NO ___ YES
2. Any unexplained fevers?	___ NO ___ YES	___ NO ___ YES
3. Night sweats?	___ NO ___ YES	___ NO ___ YES
4. Any weakness or fatigue?	___ NO ___ YES	___ NO ___ YES
5. Loss of appetite?	___ NO ___ YES	___ NO ___ YES
6. Any immune deficiencies?	___ NO ___ YES	___ NO ___ YES
Musculo-skeletal:		
7. Any joint pain?	___ NO ___ YES	___ NO ___ YES
8. Joint swelling?	___ NO ___ YES	___ NO ___ YES
9. Muscle pain?	___ NO ___ YES	___ NO ___ YES
10. Muscle cramps?	___ NO ___ YES	___ NO ___ YES
11. History of back pain?	___ NO ___ YES	___ NO ___ YES
Skin:		
12. Any rashes?	___ NO ___ YES	___ NO ___ YES
13. Changes in skin?	___ NO ___ YES	___ NO ___ YES
14. Changes in nails?	___ NO ___ YES	___ NO ___ YES
15. Changes in hair (e.g. - dryness)?	___ NO ___ YES	___ NO ___ YES
Head:		
16. Frequent headaches?	___ NO ___ YES	___ NO ___ YES
Eyes:		
17. Any eye pain? (discomfort)	___ NO ___ YES	___ NO ___ YES
18. Any double vision?	___ NO ___ YES	___ NO ___ YES
19. Any blurred vision?	___ NO ___ YES	___ NO ___ YES
Ears, Nose & Throat:		
20. Any ringing in the ears?	___ NO ___ YES	___ NO ___ YES
21. Any ear pain?	___ NO ___ YES	___ NO ___ YES
22. Any nasal discharge?	___ NO ___ YES	___ NO ___ YES
23. Any nasal bleeding?	___ NO ___ YES	___ NO ___ YES
24. Any sinus pain?	___ NO ___ YES	___ NO ___ YES
25. Any soreness?	___ NO ___ YES	___ NO ___ YES
26. Any hoarseness?	___ NO ___ YES	___ NO ___ YES
27. Any difficulty swallowing?	___ NO ___ YES	___ NO ___ YES
Respiratory:		
28. Any chest pain?	___ NO ___ YES	___ NO ___ YES
29. Wheezing?	___ NO ___ YES	___ NO ___ YES
30. Coughing?	___ NO ___ YES	___ NO ___ YES
31. Do you or have you had tuberculosis?	___ NO ___ YES	___ NO ___ YES
32. Are you a smoker?	___ NO ___ YES	___ NO ___ YES

OVER

IN THE PAST 6 MONTHS:

HAVE YOU HAD? ARE YOU BEING TREATED BY A DR. FOR?

Neurological:

- 33. Have you had any fainting or blackouts? NO YES NO YES
- 34. History of seizures? NO YES NO YES
- 35. Any memory loss? NO YES NO YES
- 36. Numbness? NO YES NO YES
- 37A. Tingling? NO YES NO YES
- 37B. Loss of bowel control? NO YES NO YES
- 37C. Loss of bladder control? NO YES NO YES

Cardiovascular:

- 38. History of heart problems? NO YES NO YES
- 39. High blood pressure? NO YES NO YES
- 40. Low blood pressure? NO YES NO YES
- 41. Any chest pains or palpitations? NO YES NO YES
- 42. Shortness of breath with normal activities? NO YES NO YES

Gastrointestinal:

- 43. Abdominal pain? NO YES NO YES
- 44. Frequent diarrhea? NO YES NO YES
- 45. Constipation? NO YES NO YES
- 46. Heart burn? NO YES NO YES
- 47. Unexplained nausea or vomiting? NO YES NO YES
- 48. History of hepatitis? NO YES NO YES
- 49. Ulcers? NO YES NO YES

Urinary:

- 50. Frequent urination? NO YES NO YES
- 51. Painful urination? NO YES NO YES
- 52. Urinary infections? NO YES NO YES

Endocrine:

- 53. History of thyroid problems? NO YES NO YES
- 54. Heat intolerance? NO YES NO YES
- 55. Cold intolerance? NO YES NO YES
- 56. Excessive sweating? NO YES NO YES
- 57. Recent increased thirst? NO YES NO YES
- 58. Recent increased appetite? NO YES NO YES

FOR MEN ONLY

- 59. Do you have a history of prostate problems? NO YES NO YES

FOR WOMEN ONLY

- 60. Personal history of breast disease? NO YES NO YES
- 61. A family history of breast cancer? NO YES NO YES
- 62. Have you ever been pregnant? NO YES NO YES
- 63. If YES, how many times? NO YES NO YES
- 64. Personal history of ovarian cancer? NO YES NO YES

SPECIAL NEEDS (check all that apply) None

Religious Cultural Emotional Communication Physical Medical

Specify _____

Patient Signature _____

Date _____



Coordinated Health

MEDICAL HISTORY/MEDICATION FORM

Patient Name _____ DOB _____

Family Physician _____ Occupation _____

Employer _____ Length of Service _____

PAST MEDICAL HISTORY

History of:	Details	History of:	Details
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Gastrointestinal	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Musculoskeletal	_____	<input type="checkbox"/> Other	_____

SURGICAL HISTORY

Type of Surgery:	Details	Type of Surgery:	Details
<input type="checkbox"/> Cardiac	_____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Gall Bladder	_____	<input type="checkbox"/> GYN	_____
<input type="checkbox"/> Appendix	_____	<input type="checkbox"/> Breast	_____
<input type="checkbox"/> Musculoskeletal	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Tonsils	_____	<input type="checkbox"/> Other	_____

FAMILY HISTORY

Family History of:	Details	Family History of:	Details
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Diabetes/Renal	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Other	_____

SOCIAL HISTORY

Do you smoke? No Yes _____ packs per day Do you drink alcohol? No Yes _____ drinks per day

ALLERGIES (medications, metals, x-ray dyes or other substances): No Yes (If yes, please list names of allergen and type of reaction.)

Have you ever experienced a reaction to anesthesia? No Yes If yes, explain _____

PRESENT MEDICATIONS (List any supplements/medications you are taking to include aspirin, vitamins, laxatives, calcium, etc.)

Name of medication/supplement/vitamin, etc.	Dose (include strength and # of pills per day)	How long have you been taking this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Patient Information Form

Race:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Declined <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown <input type="checkbox"/> White																																																									
Ethnicity:	<input type="checkbox"/> Declined <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown																																																									
Language:	<table border="0"> <tr> <td><input type="checkbox"/> Amharic</td> <td><input type="checkbox"/> Gujarathi</td> <td><input type="checkbox"/> Pennsylvania Dutch</td> </tr> <tr> <td><input type="checkbox"/> Arabic</td> <td><input type="checkbox"/> Hebrew</td> <td><input type="checkbox"/> Persian</td> </tr> <tr> <td><input type="checkbox"/> Armenian</td> <td><input type="checkbox"/> Hindi (Urdu)</td> <td><input type="checkbox"/> Polish</td> </tr> <tr> <td><input type="checkbox"/> Bengali</td> <td><input type="checkbox"/> Hungarian</td> <td><input type="checkbox"/> Portuguese</td> </tr> <tr> <td><input type="checkbox"/> Cajun</td> <td><input type="checkbox"/> Ilocano</td> <td><input type="checkbox"/> Romanian</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Italian</td> <td><input type="checkbox"/> Russian</td> </tr> <tr> <td><input type="checkbox"/> Croatian</td> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Samoan</td> </tr> <tr> <td><input type="checkbox"/> Czech</td> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Serbocroatian</td> </tr> <tr> <td><input type="checkbox"/> Danish</td> <td><input type="checkbox"/> Kru</td> <td><input type="checkbox"/> Slovak</td> </tr> <tr> <td><input type="checkbox"/> Declined</td> <td><input type="checkbox"/> Lithuanian</td> <td><input type="checkbox"/> Spanish</td> </tr> <tr> <td><input type="checkbox"/> Dutch</td> <td><input type="checkbox"/> Malayalam</td> <td><input type="checkbox"/> Swedish</td> </tr> <tr> <td><input type="checkbox"/> English</td> <td><input type="checkbox"/> Mandarin</td> <td><input type="checkbox"/> Syriac</td> </tr> <tr> <td><input type="checkbox"/> Finnish</td> <td><input type="checkbox"/> Miao (Hmong)</td> <td><input type="checkbox"/> Tagalog</td> </tr> <tr> <td><input type="checkbox"/> Formosan</td> <td><input type="checkbox"/> Moni-Khmer (Cambodian)</td> <td><input type="checkbox"/> Thai (Laotian)</td> </tr> <tr> <td><input type="checkbox"/> French</td> <td><input type="checkbox"/> Navaho</td> <td><input type="checkbox"/> Turkish</td> </tr> <tr> <td><input type="checkbox"/> French Creole</td> <td><input type="checkbox"/> Norwegian</td> <td><input type="checkbox"/> Ukrainian</td> </tr> <tr> <td><input type="checkbox"/> German</td> <td><input type="checkbox"/> Not Reported</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Greek</td> <td><input type="checkbox"/> Panjabi</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Yiddish</td> </tr> </table>	<input type="checkbox"/> Amharic	<input type="checkbox"/> Gujarathi	<input type="checkbox"/> Pennsylvania Dutch	<input type="checkbox"/> Arabic	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Persian	<input type="checkbox"/> Armenian	<input type="checkbox"/> Hindi (Urdu)	<input type="checkbox"/> Polish	<input type="checkbox"/> Bengali	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Cajun	<input type="checkbox"/> Ilocano	<input type="checkbox"/> Romanian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Italian	<input type="checkbox"/> Russian	<input type="checkbox"/> Croatian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan	<input type="checkbox"/> Czech	<input type="checkbox"/> Korean	<input type="checkbox"/> Serbocroatian	<input type="checkbox"/> Danish	<input type="checkbox"/> Kru	<input type="checkbox"/> Slovak	<input type="checkbox"/> Declined	<input type="checkbox"/> Lithuanian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Dutch	<input type="checkbox"/> Malayalam	<input type="checkbox"/> Swedish	<input type="checkbox"/> English	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Syriac	<input type="checkbox"/> Finnish	<input type="checkbox"/> Miao (Hmong)	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Formosan	<input type="checkbox"/> Moni-Khmer (Cambodian)	<input type="checkbox"/> Thai (Laotian)	<input type="checkbox"/> French	<input type="checkbox"/> Navaho	<input type="checkbox"/> Turkish	<input type="checkbox"/> French Creole	<input type="checkbox"/> Norwegian	<input type="checkbox"/> Ukrainian	<input type="checkbox"/> German	<input type="checkbox"/> Not Reported	<input type="checkbox"/> Unknown	<input type="checkbox"/> Greek	<input type="checkbox"/> Panjabi	<input type="checkbox"/> Vietnamese			<input type="checkbox"/> Yiddish
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Patient Signature



IMPORTANT PATIENT POLICIES

A. FINANCIAL POLICY AND ASSIGNMENT

While the filing of your insurance claims is a courtesy that we extend to our patients, we must emphasize that our relationship is with the undersigned and not with your insurance company. Because you have the relationship with your insurance company, if you are uncertain as to whether your insurance company will cover services rendered and/or supplies provided by CH, then you should contact your insurance company prior to incurring the expenses for such supplies and/or services.

Unless otherwise agreed by CH, payment for services is due at the time the services are rendered and/or supplies are provided. Some insurance companies may require referrals for services. It is your responsibility to obtain the referral prior to the time of service. If a referral is not presented before the service, the undersigned will be legally responsible for payment.

The undersigned hereby agrees to assign to CH all payments and benefits to which the below identified patient may be entitled for services rendered and/or supplies provided by CH and to be legally responsible to reimburse CH within thirty (30) days after receipt of a bill from CH for any amount that is not covered by the insurance companies, health maintenance or preferred provider organizations and/or other third parties that have been identified as being responsible for payment of the services rendered and/or supplies provided by CH to the below identified patient. Any bill from CH that is not paid by the undersigned within 90 days past shall be sent to collections. In that event, the undersigned will be legally responsible to reimburse CH for all reasonable collection and/or attorney fees and/or costs incurred by CH.

Patient's Initials _____

B. AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I hereby authorize CH Hospital of Allentown, L.L.C and CHS Professional Practice, P.C. (CH) and its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents to furnish and/or to receive any & all information relating to the medical condition, care, treatment and/or history of the below identified patient to and/or from the following: all insurance companies, health maintenance or preferred provider organizations and/or other third parties that may be responsible for payment of the services rendered and/or supplies provided by CH; other health care providers and/or pharmacies of the below identified patient; any third party payors that are or have been responsible for pharmacy benefits of the below identified patient; and/or to all employers and/or schools of the below identified patient.

Patient's Initials _____

C. NO GUARANTEE OF CURE OR OUTCOME

I understand that no guarantee of a cure or an outcome of care/treatment can be or is given.

Patient's Initials _____

D. DISCLOSURE OF FINANCIAL INTEREST IN REFERRALS AND YOUR FREEDOM TO CHOOSE ALTERNATE PROVIDER

WE ARE REQUIRED TO NOTIFY YOU THAT CH AND/OR ITS PHYSICIANS AND/OR ITS OTHER HEALTH CARE PROVIDERS MAY REFER YOU FOR A MEDICAL SERVICE, PRODUCT OR DEVICE OR TO A FACILITY OR BUSINESS IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST. IF THAT HAPPENS, BE ADVISED THAT YOU WILL ALWAYS HAVE THE FREEDOM TO CHOOSE AN ALTERNATE PROVIDER. FURTHER, BE ADVISED THAT A LIST OF THE FACILITIES OR BUSINESSES IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

Patient's Initials _____

E. ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

CH has a detailed document called "Notice of Privacy Practices". It contains information about the policies and practices of CH regarding patient privacy. By signing below, the undersigned acknowledges the following about the "Notice of Privacy Practices" of CH: (a) you were offered a copy of it on the below date; and (b) you may review a copy of it on the Internet by going to www.coordinatedhealth.com and/or by requesting it at the front desk of any office of CH.

Patient's Initials _____

I HAVE REVIEWED THE ABOVE AND AGREE WITH ANY TERMS AND/OR CONDITIONS SET FORTH THEREIN.

Patient Account Number

Patient Name

Date

Signature of Patient or Legal Guardian