

EDUCATION / WORK HISTORY

Emergency Contact: _____ Phone: _____ Referring Doctor: _____

WORK HISTORY

Current Job Title: _____ Employer: _____

How Long: _____ Years _____ Months _____

Prior Jobs	Job Title	Employer	Number of Years
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

In your current job, how many hours do you spend:

Sitting _____ Driving _____ Standing _____ Walking _____ Bending _____ Climbing _____
Lifting _____ Twisting _____ Gripping _____ Reaching Above Shoulder _____ Typing _____

Maximum weight that you lift or carry? _____

Have you missed work as a result of your current injury? YES NO If Yes, How Long? _____

Are You Currently Working? YES NO

EDUCATION

High School Diploma GED Vocational Training _____ Number of Years _____
 College _____ Number of Years _____ Degree _____
 Military Service Branch _____ Type of Discharge _____ Years of Service _____

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Occupational Orthopedics, LLC, to use and disclose my health and medical information for the purposes of treatment, payment, and healthcare operations.

This consent form does not constitute a change in the normal usage of your medical information. It reflects a change in the law regarding how you are informed about the appropriate uses of your medical information and requires that Occupational Orthopedics, LLC protect your information.

Your health and medical information continues to be utilized for the following purposes:

- **Treatment** (use by our Doctors and PA's who provide medical care to you, coordinating your care with other Doctors, Nurses, Therapists, and your workers' compensation, medical, and disability Insurance Companies).
- **Payment** (authorization, scheduling, billing and payment, review for medical necessity, justification of charges, pre-certification, and prior authorization).
- **Healthcare Operation** (includes the usual administrative and business functions of our office).

You may review Occupational Orthopedics, LLC, "Notice of Privacy Practices" for additional information about the use and disclosure of the information described in this consent prior to signing this consent.

I understand that I have the right to revoke or restrict this CONSENT provided that I do so in writing, except to the extent that Occupational Orthopedics, LLC, has already used or disclosed the information in reliance on this CONSENT.

Patient Name (Please Print)

Signature of Patient or Patient's Representative

Date