New Patient Welcome Sheet

Date: _____ Time: _____

WHY ARE YOU HERE TODAY?

Reason for Visit: ☐ Urgent Care ☐ Work Injury ☐ Physical Therapy/Fitness ☑ Occupational Health ☐ Drug Test

Employer Name: _____ Self Pay: ☐ Yes ☐ No

Was your visit today scheduled in advance? ☐ Yes ☐ No If yes, what was your scheduled time? _____

What are you here for Today? (Reason for Visit) 19-A Physical

For Work Injury:

Explain HOW injury happened and what BODY PART was affected:

_____

_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Social Security: _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Primary Phone: _____

Other Address: _____ Secondary Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married DL#: _____

Person to Contact in Case of Emergency: _____ Phone: _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT:

I hereby authorize WorkFit Medical and its staff and providers to examine and treat my condition as the providers deem appropriate and I give authority for those procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount(s) become necessary, I will be responsible for all charges, fees, and attorney fees. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Guardian: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Consent for
Examination, Treatment, Testing &
Release of Information

I consent to the use or disclosure of my confidential health information by WorkFit Medical, LLC for the purpose of diagnosis or treatment, obtaining payment for services rendered, and conducting operations of WorkFit Medical, LLC. My signature below is evidence of my consent for evaluation, diagnosis, or treatment by WorkFit Medical, LLC.

I understand that I have the right to request a restriction as to how my confidential health information is used or disclosed while providing treatment, payment, or health care operations of the practice. WorkFit Medical, LLC is not required to agree to the restrictions that I may request. However, if WorkFit Medical, LLC agrees to a restriction I request the restriction is binding on WorkFit Medical, LLC and the providers contracted or employed by WorkFit Medical, LLC. I have the right to revoke this consent in writing, at any time, except to the extent WorkFit Medical, LLC has taken action in reliance on this consent.

My confidential health information includes my demographic information provided by me as well as information provided by or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This confidential health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for WorkFit Medical, LLC is provided on the wall in the waiting area. I understand I have a right to review WorkFit Medical, LLC's Notice of Privacy Practice prior to signing the document. The WorkFit Medical, LLC's Notice of Privacy Practice has been provided or offered to me.

The Notice of Privacy Practice describes the types of use and disclosures of my confidential health information that will occur pursuant to treatment, payment, or in the performance of healthcare operations of WorkFit Medical, LLC. This Notice of Privacy Practice also describes my rights and the duties of WorkFit Medical, LLC with respect to my confidential health information. WorkFit Medical, LLC reserves the right to amend the Notice of Privacy Practice at any time. I may obtain a revised copy of Notice of Privacy Practice upon request.

I agree to undergo clinical examination, diagnostic tests, medical treatment, and drug and/or alcohol testing consistent with the accepted standards of care and practice. The information obtained will be used to carry out treatment plans, to determine my fitness for work, or for billing purposes. I understand that the services routinely provided by WorkFit Medical, LLC are not meant to replace medical care provided by my personal healthcare provider. I am granting permission to WorkFit Medical, LLC to release the results of the examination/treatment and drug and/or alcohol results to the company specified above.

Patient Signature: _____ Date: _____

CONSENT TO TREAT A MINOR: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian, or custodian of the minor being:
Last Name: _____ First Name: _____ M.I.: _____, Age: _____ do hereby request, and direct WorkFit Medical, LLC, its providers, and staff to perform examinations, diagnostic X-Rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's providers and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I(we) will be personally responsible for payment of them. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____

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NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

MEDICAL EXAMINATION REPORT OF DRIVER UNDER ARTICLE 19-A

dmv.ny.gov

INSTRUCTIONS TO MEDICAL EXAMINER: The complete standards and instructions for conducting this examination are found in Section 6.10 of the Commissioner's Regulations, 15NYCRR6, and can be found at dmv.ny.gov/art19. They are also available from the driver's carrier named below or from the Bus Driver Unit. **For New/Initial Examinations and Recertification–**review/complete **ALL** items on the form and sign where indicated on last page. **For Follow-up Examinations–**complete **ONLY** those items which require follow-up information and/or evaluation from a prior examination. Sign the form where indicated. If additional space is required for further comments and information, use form DS-874C, and attach it to this form.

1 DRIVER/CARRIER INFORMATION *(to be completed by the driver and/or driver's carrier)*

Driver's Last Name	First	M.I.	Date of Birth (Month/Day/Year)	Age	Sex ☐ Male ☐ Female

Street Address	City	State	Zip Code

License ID Number (from Driver License)	State	Class of Driver's License	Endorsements	Restrictions	Expiration Date

Carrier/DBA Name	Legal Name (if different)	19-A Business ID Number

2 HEALTH HISTORY *(to be completed by the driver and reviewed by the medical examiner)*

Yes	No		Yes	No		Yes	No	
☐	☐	Any illness or injury in the last 5 years?	☐	☐	Kidney disease, dialysis	☐	☐	Stroke or paralysis
☐	☐	Head/Brain injuries, disorders or illnesses	☐	☐	Liver disease	☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Seizures, epilepsy	☐	☐	Digestive problems	☐	☐	Spinal injury or disease
☐	☐	Eye disorders or impaired vision (except corrective lenses)	☐	☐	Diabetes or elevated blood sugar controlled by *(check all that apply)*: ☐ diet ☐ insulin ☐ other medication	☐	☐	Chronic low back pain
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Incident of hyperglycemic or hypoglycemic shock	☐	☐	Regular, frequent alcohol use
☐	☐	Heart disease or heart attack; other cardiovascular condition	☐	☐	Loss of, or altered consciousness	☐	☐	Narcotic or habit forming drug use
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	Fainting, dizziness	☐	☐	Tuberculosis
☐	☐	High blood pressure	☐	☐	Nervous or psychiatric disorders, e.g., severe depression	☐	☐	Other _____
☐	☐	Muscular disease	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, obstructive sleep apnea, loud snoring			
☐	☐	Shortness of breath						
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis						

For any YES answer, the driver should indicate the condition, onset date, diagnosis, treating medical examiner's name and address, and any current conditions or comments here: _____

List all medications (including over-the-counter medications) used regularly or recently. _____

☐ ***Additional comments/medications on attached DS-874C***

I certify that the above information and any other information on any accompanying DS-874C, if used, is complete and true. I understand that inaccurate, false or missing information may invalidate this examination.

➧ _____ _____

(Driver's Signature) (Date)

Medical Examiner's Comments: _____

TESTING (SECTIONS 3 THROUGH 8 TO BE COMPLETED BY THE MEDICAL EXAMINER)

3 VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors..... ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing corrective lenses..... ☐ Yes ☐ No

Does applicant have monocular vision?..... ☐ Yes ☐ No

Complete next two lines only if vision testing is done by an ophthalmologist or optometrist.

Date of Examination | Name of Ophthalmologist or Optometrist (print) | Telephone Number

License Number/State of Issue | ➧ (Signature of Examiner)

4 BLOOD PRESSURE/PULSE RATE

Standard: If the blood pressure is consistently above 160/90 mm. Hg., further testing may be necessary to determine whether the driver is qualified to operate a bus. Numerical reading must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure Readings	1) Systolic/Diastolic	2) Systolic/Diastolic

Pulse Rate: ☐ Regular ☐ Irregular **Record Pulse Rate:** _____

Date of Examination

Driver's Name: Last _____ First _____ MI _____ Driver's License ID #_____

5 HEARING Standard: **a)** Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or **b)** average hearing loss in better ear ≤ 40 dB

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

a) Record distance in feet from individual at which forced whispered voice can first be heard.

Right ear \Feet	Left ear \Feet

OR

b) If audiometer is used, record hearing loss in decibels.(acc. to ANSI Z24.5-1951)

Right Ear			Left Ear		
500Hz	1000 Hz	2000 Hz	500Hz	1000 Hz	2000 Hz
Average:			Average:		

6 LABORATORY AND OTHER TEST FINDINGS -

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record):

URINE SPECIMEN

SP. GR	PROTEIN	BLOOD	SUGAR

7 PHYSICAL EXAMINATION *(to be completed by the medical examiner)* - Height _____ (in.) Weight _____ (lbs.)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for.

BODY SYSTEM	CHECK FOR:	Yes*	No	BODY SYSTEM	CHECK FOR:	Yes*	No
1. General appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse	☐	☐	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness	☐	☐
2. Eyes	Pupillary equality, reaction to light accommodation, ocular motility, ocular muscle imbalance extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate	☐	☐	8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins	☐	☐
				9. Genito-urinary System	Hernias.	☐	☐
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums	☐	☐	10. Extremities- Limb impaired.	Loss or impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	☐	☐
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	☐	☐				
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	☐	☐	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness	☐	☐
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest	☐	☐	12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski reflexes, ataxia.	☐	☐

*** MEDICAL EXAMINER'S COMMENTS:** _____

☐ ***Additional comments on attached DS-874C.***

8 MEDICAL EXAMINER'S CERTIFICATION: ☐ **New/Initial Certification** ☐ **Recertification** ☐ **Follow-Up**

I certify that I have examined (*Print Driver's Full Name*)_____ in accordance with the Commissioner's Regulations and with knowledge of the driver's duties. In accordance with Commissioner's Regulation 6.10, I find:

- ☐ the person named above is physically or medically qualified.
- ☐ the person named above **IS NOT** physically or medically qualified because_____
- ☐ the person named above is physically or medically qualified with **Restrictions and/or Follow-up** as detailed below:
  - ☐ Qualified only when wearing corrective/contact lenses.
  - ☐ Qualified - Certification required every six months for **diabetic condition**.
  - ☐ Qualified only when wearing a hearing aid.
  - ☐ Qualified only by use of prosthetic devices or equipment modifications. Description/Type: _____
  - ☐ Qualified, other: _____

REMARKS: _____ ☐ ***Additional comments on attached DS-874C.***

Print name and check title of: _____ Date: _____

- ☐ Examining Physician
- ☐ Nurse Practitioner
- ☐ Physician Assistant
- ☐ Advanced Practice Nurse*
  (who is not a Nurse Practitioner)

Signature of Examiner: _____

Address of Examiner: _____

License or Certificate No./Issuing State _____

* If the examination is conducted by an Advanced Practice Nurse, who is not a Nurse Practitioner, the Supervising Physician must certify as follows:
I certify that the individual who conducted the above examination was acting under my direction and supervision and, if applicable, in accordance with a written practice or protocol agreement.

Print _____ _____ _____

(Name of Supervising Physician) (Signature of Supervising Physician) License or Certificate No./Issuing State

THE CARRIER MUST KEEP THE ORIGINAL EXAMINATION REPORT (NOT A PHOTOCOPY) IN THE EMPLOYEE'S 19-A FILE ANY PHOTOCOPIES MUST IDENTIFY THE LOCATION OF THE ORIGINAL