ONSITE MEDICAL
EMPLOYEE HEALTH AND WELLNESS

Patient Information			
Legal First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Preferred Name (if applicable):		**Status**: Single ☐ Married ☐ Other ☐	
Date of Birth:	**Social Security#:**	**Sex assigned at Birth:** ☐Male ☐Female ☐Unknown	
Patient Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other **Is the patient Hispanic?** ☐ Yes ☐ No		**Optional (circle one)** **Gender Identity:** Male ☐ Female ☐ Non-Binary ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ **Sexual Orientation:** Straight ☐ Asexual ☐ Bisexual ☐ Lesbian ☐ Gay ☐ Choose not to disclose ☐	
Mailing Address:		**Apt#:**	
City/State/Zip:		**Personal Email:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	**ext:**
Preferred method of communication: Home Phone Cell Phone Work Phone		**Primary Care Provider's name/ contact#:**	
Preferred Pharmacy Name/location:			

Employee and Insurance information			
Employer Information: CMCSS ☐ or Montgomery County ☐		Who is employed? ☐ Self ☐ Spouse ☐ Parent	
Position/Title:		School/Department:	
Do you have CMCSS/County BCBS-S Yes ☐ or No ☐		Subscriber MUNIS# (CMCSS only):	
Insurance Subscriber's Legal Name:		Subscriber Phone:	
Subscriber CKR #	Subscriber SSN:	Subscribers DOB:	

Emergency Contact Information		
Name:	**Relationship to patient:**	**Phone:**

Permission to Contact		
May we call and leave a voicemail on your home phone regarding appointments, labs, and test results?	YES ☐	NO ☐
May we call and leave a voicemail on your cell phone regarding appointments, labs, and test results?	YES ☐	NO ☐
May we text you on your cell phone regarding appointments, labs, and test results?	YES ☐	NO ☐
If we are unable to reach you by phone, may we mail results to your home?	YES ☐	NO ☐
Onsite Employee Health and Wellness can release medical information to specified person other than you? If yes, Authorized Persons Name: Relationship to patient:	YES ☐	NO ☐

Protected Health Information

I authorize Onside Employee Health and Wellness providers and staff to render medical treatment and evaluations as needed. I hereby give my consent to Onsite Employee Health and Wellness to use or disclose, for the purpose of carrying out treatment, payroll deduction information or healthcare collaboration operations, all protected health information contained in the patient record.

_____ _____

Patient Signature (Parent/Legal Guardian) Date

Patient Name:_____

Date of Birth:_____

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Medical History

MEDICAL HISTORY

Patient		Family member/ relationship	
Seizures	☐ Yes ☐ No		Yes ☐ No ☐
Diabetes	☐ Yes ☐ No		Yes ☐ No ☐
Heart Issues	☐ Yes ☐ No		Yes ☐ No ☐
Chicken Pox	☐ Yes ☐ No		Yes ☐ No ☐
Measles	☐ Yes ☐ No		Yes ☐ No ☐
Ear Infections	☐ Yes ☐ No		Yes ☐ No ☐
Hearing Loss	☐ Yes ☐ No		Yes ☐ No ☐
COPD	☐ Yes ☐ No		Yes ☐ No ☐
GI Issues	☐ Yes ☐ No		Yes ☐ No ☐
Mental Health Issues	☐ Yes ☐ No		Yes ☐ No ☐
Epilepsy	☐ Yes ☐ No		Yes ☐ No ☐
Asthma	☐ Yes ☐ No		Yes ☐ No ☐
Headaches/Migraines	☐ Yes ☐ No		Yes ☐ No ☐
Anemia	☐ Yes ☐ No		Yes ☐ No ☐
HIV (patient only)	☐ Yes ☐ No		Yes ☐ No ☐
Thyroid	☐ Yes ☐ No		Yes ☐ No ☐
High/Low Blood Pressure	☐ Yes ☐ No		Yes ☐ No ☐
Stroke	☐ Yes ☐ No		Yes ☐ No ☐
Liver	☐ Yes ☐ No		Yes ☐ No ☐
Glaucoma	☐ Yes ☐ No		Yes ☐ No ☐
Cataracts	☐ Yes ☐ No		Yes ☐ No ☐
Kidney	☐ Yes ☐ No		Yes ☐ No ☐
Cancer (Type:_____)	☐ Yes ☐ No		Yes ☐ No ☐
Other:	☐ Yes ☐ No		Yes ☐ No ☐

Allergies

Surgeries

Current Medications/Dosage

_____ _____

Patient Signature (Parent/Legal Guardian) Date

Patient Name:_____

Date of Birth:_____

Please read below and initial each line

_____ **Registration forms**

- Refusing to complete a registration form will result in you no longer being able to use the clinic.
- Form must be completed yearly or when requested by Onsite.

_____ **Appointments**

- Provider subject to change without notice.
- Medication Refills require an appointment.
- Outside Lab Orders and Allergy Injections are subject to approval before service can be provided.
- Parents must remain with minor children while in the clinic unless parent has signed release for minor to be seen unaccompanied.

_____ **Telehealth appointments**

- Appointments are at our medical discretion / depending on the reason, you may require an in-person visit.

_____ **HIPAA**

- Copy provided upon patient request.

_____ **Medical Records**

- Patients can request their own medical records once per year at no charge.

_____ **No show / Late Fees**

- All Onsite appointments have a 5 minute grace period. Arrival times over 5 minutes will be charged a $20 late fee for clinic appointments / $40 Counselor appointments.
- Clinic appointments must be cancelled 2+ hours to avoid $20 fee.
- Counselor appointments must be cancelled 24+ hours to avoid $40 fee
- **Fee Disputes – by EMAIL ONLY**
  sharla.smith@cmcss.net
  tiffany.maxwell@cmcss.net

_____ **Clinic is a privilege not a right**

- Onsite has the right to refuse service.
- We have a zero-tolerance policy towards any form of disrespect, verbal abuse, or physical aggression directed at our medical staff. Patients who engage in such unacceptable behavior will lose their privilege to utilize our facilities for their medical needs. Our commitment to providing a safe and supportive environment for both our staff and patients is paramount, and we will take all necessary measures to uphold this standard.

_____ **PRIVACY NOTICE**

- By signing this consent, I understand and agree to the use and disclosure of my health information as explained in the Notice of Privacy Practices.
- I can revoke this consent by submitting a written request to the Clinic Manager.
- Copy of Notice of Privacy Practices provided upon patient request.

_____ _____

Patient Signature (Parent/Legal Guardian) Date