



**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ FIRST NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Can we leave a voicemail regarding NORMAL results? (Y) (N)

EMAIL ADDRESS: \_\_\_\_\_@\_\_\_\_\_.com

Can we contact you in future via this email address? (Y) (N)

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_ MARITAL STATUS: S M D W (CIRCLE) SEX: M F  
SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

**INSURANCE HOLDER INFORMATION**

MEDICAL INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_

POLICY HOLDER SOCIAL SECURITY NUMBER (if different from above): \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH (if different from above): \_\_\_\_\_

**EMERGENCY NOTIFICATION**

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
\_\_\_\_\_



**ASSIGNMENT OF INSURANCE BENEFITS AND NOTICE OF PRIVACY PRACTICES AND THE RELEASE OF INFORMATION**

If your insurance is an HMO, POS, or MC plan and University Health and Urgent Care is not listed as your primary care provider, I the undersigned understand and agree that I am fully responsible for any out of network and deductible payments that are not covered by your insurance.

The, undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned had personally signed the particular claim.

I understand and agree that should the insurance card I present today be invalid, expired, incorrect in any way, or not the appropriate card for my current insurance, that I will be personally financially responsible for any charges incurred as a result of such error. I also agree that it is my responsibility to present the correct insurance card at the time of each visit I further agree to accept responsibility for any bills incurred that are denied by my current Insurance company for any reason including timely filing as a result of my failing to present an appropriate insurance card or presenting inaccurate or incorrect personal information, including old or invalid insurance cards, licenses or other identifying information.

I also understand and agree that Is it within the rights of University Health and Urgent Care to collect any outstanding charges by billing me personally through any collection method including phone, mail or collection agency. Should such delinquent accounts remain unpaid after 90 days, University Health and Urgent Care or its agents may forward such accounts to a collection agency and that such accounts may be reported to a national collection bureau. I hold University Health and Urgent Care, its agents or assignees harmless for any and all damages resulting from such action.

I understand and agree that if I do not have insurance, I will be responsible for all charges incurred today due in full at the end of my visit unless other arrangements were made prior to my visit.

I (name) \_\_\_\_\_ hereby authorize my insurance carrier to pay and hereby assign directly to University Health and Urgent Care all benefits, if any otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to University Health and Urgent Care, will be credited to my account. in accordance with the above said assignment.

**Your signature below acknowledges that you read agree to the above and that you have received the Notice of Privacy Practices and the Release of Information.**

**If the patient is a minor (under the age of 18), please sign on their behalf.**

**Print name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**IMMUNIZATIONS**

Vaccination	Year/Never
Pneumonia (pneumovax)	_____
Tetanus booster (Tdap)	_____
TB skin test (PPD)	_____
Hepatitis B vaccine	_____
Hepatitis A vaccine	_____
Varicella (chicken pox)	_____
Singles (Zostavax)	_____

**PREVENTATIVE CARE**

Test or procedure	Date and result/Never
Colonoscopy	_____
Bone Density Test (DXA)	_____
Cholesterol Test	_____
PSA (prostate cancer test)	_____
Pap smear	_____
Mammogram	_____
HIV test	_____
Hepatitis C screen	_____

**OTHER HEALTH ISSUES**

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? Yes / No If yes, please describe:

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**ALLERGIES** List medication allergies and the type of reaction you had:

- I have no drug allergies
- I have a latex allergy

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**MEDICATIONS** List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed.

- None

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**FAMILY HISTORY** (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental Illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										

**YOUR MEDICAL CONDITIONS**

(check all that apply)

- Seasonal Allergies
- Anemia
- Anxiety
- Arthritis
- Asthma
- Cancer - type \_\_\_\_\_
- Clotting disorder
- Congestive heart failure
- Depression
- Diabetes mellitus
- Emphysema / COPD
- Gastroesophageal reflux disease (GERD)
- Glaucoma
- Heart murmur
- HIV/AIDS
- High cholesterol
- Hypertension / high blood pressure
- Hepatitis B
- Hepatitis C
- Kidney Disease
- Myocardial infarction
- Nerve/muscle disease
- Osteoporosis
- Seizures
- Sick cell anemia
- Substance abuse
- Thyroid disease
- Tuberculosis

Have you ever had a blood transfusion?

No / Yes – approximate dates:

\_\_\_\_\_

**HABITS AND ACTIVITIES**

(please circle your answer)

Do you use tobacco? No / Yes

If in the past – how many years since you quit \_\_\_\_\_

If yes, what form? \_\_\_\_\_

\_\_\_\_\_

If yes, have you tried to quit? Yes / No

If yes, would you like to quit? Yes / No

Do you drink alcohol? No / Yes / In the past

If yes, how many drinks per week? \_\_\_\_\_

Have you ever used recreational drugs? No / Yes

If yes, please describe: \_\_\_\_\_

**SURGICAL HISTORY**

(check all that apply)

- Appendectomy
- Brain Surgery
- Breast surgery
- CABG
- Cholecystectomy
- Colon surgery
- Tonsillectomy
- Thyroid surgery
- Lung surgery
- C – section
- Eye surgery
- Fracture surgery
- Hernia repair
- Hysterectomy
- Joint surgery
- Bunionectomy
- Varicose vein surgery
- Prostate surgery
- Weight reduction surgery
- Spine surgery
- Tubal ligation
- Valve replacement
- Vasectomy
- Vascular surgery
- Cardiac stent
- Bladder surgery

\_\_\_\_\_

Do you get regular exercise? No / Yes

If yes, what kind of exercise?

\_\_\_\_\_

\_\_\_\_\_

How often? Daily / Weekly / Monthly

\_\_\_\_\_

## COVID19 SCREENING QUESTIONNAIRE

**Introduction:** These questions are intended to assist us in diagnosing you for COVID-19. As a result, it is important that you answer these questions truthfully and accurately.

Question	Y/N	Explanation
Have you or a member of your household had any of the following symptoms in the past 30 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped.)		
Have you or a member of your household been tested for COVID-19?		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, explain)		
Have you or a member of your household traveled Inside / outside the U.S. in the past 30 days? (If yes, explain)		
Are you or a member of your household healthcare providers or emergency responders?		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)		